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ABSTRACT

To identify learning program needs and to make recommendations for quality control and expansion of programs for the mentally handicapped in institutions, four facilities were studied. Detailed questionnaires and visitations were used to obtain the information. The major findings were that learning programs in Minnesota State Institutions are operating at minimum levels in terms of daily support and in numbers of residents served, and that there exists a basic inability to give meaningful learning experiences to most institutionalized persons. Recommendations include broader and more flexible funding, closer involvement of the State Department of Education and local school districts, and the establishment of closer ties between institutional programs and the local educational agency in administration, supervision, and funding. Descriptions of the existing programs, extensive recommendations for the future, and appendixes presenting findings of data are provided. (JM)

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MINNESOTA
NATIONAL
LABORATORY

PROGRAMS OF LEARNING IN MINNESOTA'S INSTITUTIONS FOR THE MENTALLY RETARDED

A STUDY

EC 5461E

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ED037881

A Study of Education Programs
in
Minnesota's Institutions for the Mentally Retarded

February, 1969

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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PREFACE

This study of educational programs in institutions for the mentally retarded in Minnesota was conducted under the auspices of the Minnesota Departments of Public Welfare and Education, and was initiated to investigate ways in which these programs could be improved.

The increase in quantity and quality of educational technology, the rapid development of community-based services, the growth in Federal funding opportunities for educational programs for handicapped and disadvantaged children and adults, the changing role of the public schools in the Nation and in Minnesota with regard to provision of services for marginal populations, increased knowledge about the learning process, recent legislative developments, and population mobility have all combined to create a climate for progress, and to demand that we continually evaluate and modify our systems for educating handicapped children and adults.

The purpose of this study is to (1) analyze and evaluate existing institutional services and life adjustment needs of those in residence, and (2) make recommendations for improving systems of service dedicated to meeting those needs.

Chapter 1 lists the major recommendations in summary form. The other chapters provide background information, detailed rationale, and related information necessary to the full understanding of each recommendation.

ACKNOWLEDGEMENTS

Many persons contributed to the conduct of the study. Primary recognition is given to the staff members at the institutions who spent many hours and much effort in gathering information and discussing programs with Study Staff. The Study Staff was reassured by the sincere interest of staff members at Brainerd, Cambridge, Faribault, and Owatonna in providing educational programs of high quality. The results of this study are dedicated to them, with the hope that they will be of help in defining and improving future educational program directions.

The assistance of the State Department of Public Welfare personnel in gathering statistical and other data is also gratefully acknowledged.

Personnel from the State Department of Education, the Division of Vocational Rehabilitation and Special Education, were very helpful to this Study Staff.

The Staff also received much information and good counsel from Mr. Wayne Larson, Director, Crow Wing County Welfare Department, and from Mr. Elliot Whoolery, Superintendent of Schools, Brainerd Public Schools.

To the above persons, and the many others who offered information and guidance, the Minnesota National Laboratory and the Study Staff offer their thanks.

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CHAPTER I

SUMMARY OF MAJOR RECOMMENDATIONS

This summary is provided for those who wish an overview of the major recommendations made by the Study Team. Only recommendations of major importance and which pertain to more than one institution are summarized here. Chapter V contains other specific suggestions for program improvement. Chapter VI contains a detailed description and rationale for each major recommendation summarized in this chapter.

Recommendations are summarized under four major headings. These are:

A. Recommendations germane to the total welfare/institutional system for mentally retarded children and adults.

B. Recommendations germane to the operation of other state and local agencies.

C. Recommendations germane to the on-going conduct of the learning programs in the institution for the mentally retarded.

D. Recommendations for further study.

A. RECOMMENDATIONS GERMANE TO THE TOTAL WELFARE INSTITUTIONAL SYSTEM FOR MENTALLY RETARDED CHILDREN AND ADULTS.

This first category of recommendations may go beyond the charge to the Study Team. However, it is clear to the Study Team that the structure of large medically and custodially oriented residential institutions is inimical to programs planned to facilitate improvement in individual adaptive behavior. These recommendations are pertinent in that they deal with reduction of these institutional settings to more manageable environments where learning can more feasibly be facilitated. This represents one of the best, and in the long run, most economical ways of improving the functional level of those mentally retarded persons not able to remain at home with their families.

Recommendation 1

A system of smaller residential care facilities should be located throughout the state according to population density and characteristics. Placement in large institutions removed from proximity to home and community, where scarce and expensive resources would have to be pooled, should then be reserved for those few individuals whose physical and medical needs are too great to be met through local or regional programs, and whose organic condition is so poor that complete custodial and nursing care will be needed on a long term basis. Facilities now available at the community level should be used with more regularity, rather than being ruled out primarily on the basis of cost to the county.

Recommendation 2

For those individuals who can be served in smaller residential facilities, the major program and administrative elements of these facilities should be determined by the learning and life adjustment needs of the residents.

Recommendation 3

The present system of making decisions regarding institutionalization should more specifically include, in addition to specialists in welfare, family status, medicine and law, specialists skilled in learning and behavior development areas. The concept of a regional or county inter-agency clearinghouse for case management of handicapped persons should be explored and considered.

B. RECOMMENDATIONS GERMANE TO THE RESPONSIBILITY AND OPERATIONS OF OTHER STATE AND LOCAL AGENCIES.

Recommendation 1

Programs designed to meet the learning needs of the mentally retarded should be under the administrative, technical, and financial regulation and support of the State Department of Education. Persons who reside in state institutions should not be considered exceptions to the general policy of having educational responsibility lodged in the State Department of Education. The legal mechanism for maintaining State Education Agency responsibility for learning services to the institutionalized mentally retarded should be the local public educational agency.

C. RECOMMENDATIONS GERMANE TO THE CONDUCT OF THE LEARNING PROGRAMS IN THE VARIOUS INSTITUTIONS FOR THE MENTALLY RETARDED.

Recommendation 1

A full-time state level consultant in educational programs for the institutionalized mentally retarded should be employed and assigned to work with the various institutions on development of quality programs for learning.

Recommendation 2

Comprehensive in-service training experiences of all types designed specifically to support staff assigned to programs of learning should be given major priority, direction, and support by both State and institutional level leadership personnel.

Recommendation 3

Programs designed to meet learning and life adjustment needs of the institutionalized mentally retarded should be given a much higher priority for support than now exists, and should be administratively designed to facilitate the provision of quality programs of learning for all residents. These programs should be considered a major focus of the institutional program for all residents, and should be expanded accordingly.

Recommendation 4

The beginning efforts of some institutions to extend formal programs of learning to all corners of the institution and community should be encouraged and expanded.

Recommendation 5

Vocational evaluation, work adjustment, and pre-vocational training should be major and integral components of each institution's program of learning and should be more closely coordinated with the other formal program components.

Recommendation 6

A formal information system designed to monitor individual potential, progress, and outcome in learning and life adjustment should be established, and should be linked to a more effective program communication network in each institution.

Recommendation 7

Diagnostic services available to the learning programs staff should be expanded to include the services of an educational psychologist skilled in psycho-educational assessment and remediation processes.

Recommendation 8

The use of para-professional personnel in support of programs for learning, as observed in some institutions, should be encouraged and expanded.

Recommendation 9

A special task force of program consultants should be sent to each institution on a regular basis (1 to 2 days a month) to assist with the difficult problems of upgrading learning programs, and to assist with implementation of the recommendations contained in this Report.

Recommendation 10

Workshops offering long-term sheltered employment should be established to serve clients from both the institution and the community area. These workshops should be located off the grounds of the institution.

Recommendation 11

The budget available for instructional tools of learning should be greatly increased, and plans should be made to relate in some formal way with one of the Special Education Instructional Materials Centers in Minnesota, or to begin a satellite program serving the special needs of both the institutional and the local public school special education program.

Recommendation 12

Consideration should be given to designating specific institutions as "special purpose" facilities designed to focus scarce and expensive resources to meet more effectively the learning needs of special groups of the institutionalized mentally retarded.

D. RECOMMENDATIONS FOR FURTHER STUDY

Recommendation 1

A thorough study of the Owatonna State School should be made, with the primary purpose of determining (1) its appropriate mission and (2) its role in relationship to other social and educational resources.

Recommendation 2

A comprehensive study should be conducted to investigate utilizing various local educational agencies as vehicles for increased, more flexible funding, and for program development and supervision.

CHAPTER II

STATEMENT OF THE PROBLEM

Education is now an active and highly visible concern of society. This concern takes many forms, ranging from violent confrontation to deeply pondered questions of purpose and method. There are as yet no commonly agreed upon answers to this concern. The answers which have been presented are by no means definitive or final, and perhaps never will be. It is quite possible that the search for final answers is an illusion.

However, this does not absolve responsible authority from the need to take constructive action on as reasonable a basis as is possible. It is in this spirit that the present study of learning programs in the state institutions for the retarded was undertaken.

In the past decade society has for the first time made a serious demand that education become truly universal. Education for all has indeed been a historical shibboleth, and "Education 1967" states that "A primary historical aim of elementary education is to reach all children. (This aim) has now in a large measure been accomplished." In practice, society has until recently made an exception to the requirement that education be offered to every child. That exception was that a person who is difficult to educate, or whose educational and learning needs are not served by the standard facilities and methods, was outside the pale of education. This exception is now intolerable. It has become intolerable. It has become intolerable because society can no longer afford the consequences of refusing education to some of its citizens, because we no longer have the excuse that we do not know how to provide a meaningful program of education to these people and, above all, because the granting of this exception is the violation of a clear civil and human right.

Among those who have denied access to ordinary educational resources are many residents of the state institutions for the retarded. This was perhaps a reasonable denial in the days when mental retardation was thought to be a "thing" in the person which explained him and was thought to be incurable by definition. It is no longer reasonable in a time when mental retardation is viewed as only a description of the level of the person's adaptive behavior, and is caused by a number of conditions, some of which are still as untreatable as the presence of an extra chromosome, but some of which are as treatable as the lack of structured opportunity to learn more effective behavior.

A host of services to the mentally retarded have come into being within the last few years. Many of the services are based in the community rather than in segregated institutions. One of the results has been a decreasing use of institutional placement for the management of retardation, and another has been a successful attempt to return previously institutionalized people into life in the normal community. In both of these trends, the provision of learning experiences which improve the retarded person's adaptive behavior has played a crucial role. New learning technologies have been evolved in the course of this progress, so that society now knows how to educate people who were previously considered incapable of learning. One concern which motivates the present study is that these learning technologies be most effectively applied.

The state institutions for the retarded in Minnesota have been historically considered to be "hospitals." Mental retardation, as it falls within the responsibility of the institutions, does indeed often have a medical dimension. However, when mental retardation is viewed as a "sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior" (American Association on Mental Deficiency) and when it is realized that level of functioning and adaptive behavior are appropriate subjects of programs of learning, then it is clear that education and learning must be a major focus in the management of children and adults who are defined as mentally retarded. Concern that education and training be an effective and major part of the management of mental retardation in the Minnesota institutions for the retarded is a primary reason for undertaking the study reported here.

Dr. David J. Vail, Director of the Medical Services Division in the Minnesota State Department of Public Welfare, formulated the charge for this Study in a memorandum dated March 12, 1968. He stated that, "The purpose of this study by the Minnesota National Laboratory is:

"1. To describe the current programs of education and training in Minnesota's institutions for the retarded.

"2. To assess the needs for education and training as they exist in these institutions, including evaluation of children as needed by institutions staff.

"3. To determine how present programs are meeting needs and to identify and describe areas of current educational and training needs.

"4. To analyze laws to see how their provisions for grants and other aides may be utilized to provide for current needs in the area of training and education.

"5. To suggest in broad outline proposals and projects that may be written and submitted under various laws to meet determined needs."

The degree to which this charge was carried out, the Study design, the findings, and recommendations made by the Study Team are detailed in the following chapters.

CHAPTER III

THE STUDY: DESIGN AND IMPLEMENTATION

As was pointed out in Chapter II, this Study was commissioned to study education programs in Minnesota's public institutions for the mentally retarded to 1) describe current programming, 2) judge the effectiveness of the programs of education, 3) assess needs, 4) analyze laws relevant to program funding, and 5) suggest proposals which might obtain needed funding. With the exception of the last, this Study Report reflects attention to each of these points, with major focus on the first three.

This Study, funded by the Elementary and Secondary Education Act, Title I, was a cooperative venture requested by the Minnesota Department of Public Welfare, Medical Services Division, and by the Minnesota Department of Education, Title I Office. The Study was contracted in March, 1968, to the Minnesota National Laboratory, a program evaluation and research arm of the Minnesota State Department of Education. In April, a team of consultants and a Study Director were retained on a part-time basis to advise the Minnesota National Laboratory on design and procedures, to do the necessary field studies, and to make a report of findings and recommendations.

The conduct of the study was divided into a number of phases, briefly stated below:

1. Planning Phase
   - orientation of consultants and assignment of major duties
   - preliminary construction of data collection instruments and techniques
   - informational meetings to orient key institutional staff to the purposes of the study

2. Site Visits
    - to the State Institutions
    - to other resources for the mentally retarded
3. Community and Agency Contact Phase
    - contact with state officials from other agencies such as Education, Vocational Rehabilitation, etc.
    - contact with representatives of parent groups
    - discussions with local public school and welfare executives
    - contacts with professionals in other states
4. Data Collection Phase
    - refinement of questionnaires
    - distribution to institutional personnel
    - obtaining data from Department of Public Welfare and from out-of-state resources
5. Information Processing and Evaluation Phase
    - organizing data
    - securing additional information as necessary
    - structuring conclusions and recommendations
6. Report Writing Phase
    - draft
    - consultant review

During the site visitation, data collection, and community contact phases, consultants concentrated on gathering data and impressions both through formal instruments and through personal contacts and discussions. The purpose of these phases was to gather information relative to assessing the existing:

- program philosophy
- model for overall supervision and administration
- technical leadership of program
- financing patterns and options
- information processing and retrieval systems
- program evaluation and research systems

- personnel recruitment and staff development focus and techniques
- systems for patient evaluation and case management
- systems for program planning and modification
- staff attitudes, competencies, and general staffing levels
- methods of deploying staff
- relevancy and adequacy of physical space, equipment, and related "tools" of learning

In most of the institutions, Study consultants did not limit themselves to discussions with rehabilitation therapies and instructional personnel, but also talked with Superintendents and other administrative or supportive staff.

It should be pointed out that the Study Staff did not, in discussing and analyzing current status and needs, see this Study as one that would recommend, for example, the addition of specific numbers of teachers or other staff, specific equipment or supply items for each institution, or addition of $40.00, $50.00, or $500.00 per patient for "tools" of learning. The Study consultants, for the most part, concentrated on evaluating those systems, and on making recommendations, which might enhance the ability of local and state personnel to be more effective in designing and implementing programs, and in lending support for expansion of those current programs and strategies which seemed effective.

Certainly, as Chapters V and VI detail, more staff, equipment, and supplies are needed, but the specifics should be the perogative of local personnel, in conjunction with expert consultation. This Study does not replace the need for the ongoing process of local determination of priorities for today's needs, but only attempts to focus on ways in which local personnel could more effectively function.

CHAPTER IV

MINNESOTA'S INSTITUTIONS FOR THE MENTALLY RETARDED

There are four major State institutions for the mentally retarded in Minnesota. Three of them (at Brainerd, Cambridge, and Faribault) serve a general institutionalized mentally retarded population. The State School at Owatonna is specialized for the management of a relatively small group of educable retarded minors.

In Minnesota, mentally retarded persons may be committed to the guardianship of the Commissioner of Public Welfare; they are not committed directly to an institution. If institutional care is appropriate and space available, the individual may be placed in an institution. As of June 30th, 1968, there were 4,858 persons in institutions for the mentally retarded. During the fiscal year 1967-68, there was a net decrease of 470 residents in the institutions for the mentally retarded; this decrease is characteristic of a trend which began in 1964.[1] Until that date, institutional populations had steadily increased.

The institutions differ in size, with the three general institutions being comparatively large. The population on the books of the four institutions in June, 1968 were: Brainerd, 1,314; Cambridge and its annex at Lake Owasso, 1,537; Faribault, 2,498; and Owatonna, 187.

There are mentally retarded persons in other state facilities in addition to the four institutions reported here. Twenty-nine retarded children are placed for care at the women's reformatory at

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[1] See Appendix A, Table 1.

Shakopee. Transfers and primary placements have been made to state institutions for the mentally ill when those placements have been determined to be appropriate. (Those retarded persons who are not placed in the four major institutions are outside the scope of the Study reported here. They - especially those in the occupationally oriented program at St. Peter State Hospital - have some influence upon the nature of the programs for those who remain in the institutions designed exclusively for the mentally retarded. However, the St. Peter Program, at this writing, is still too new to assess.)

Three-fourths of the residents of the institutions have mentally retardation as their single diagnosis. Most of the other one-fourth are epileptic in addition to being retarded. The degree of retardation in about 37% is severe or profound (IQ under 30), and approximately an equal percentage are considered to be moderately retarded (IQ range 30-50). About 15% are mildly retarded (IQ range 50-70) and between 2 and 3% are either borderline or not mentally retarded. About one in 10 is unclassified in this description of levels.[1]

One-third of the institutions' populations are in the age range of 5 through 19. This corresponds to the ordinary public school age range. About one in a thousand is under age five. The young adult range of 20 through 29 comprises about a quarter of the population of the institutions. Nearly half of the residents are over age 30.[2]

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[1] See Appendix A, Table 2.
[2] See Appendix A, Table 3.

The three general institutions are each primarily responsible for an area of the state.[1] Brainerd serves northern Minnesota, Cambridge central Minnesota, and Faribault the southern area. Transfers and other factors (Brainerd was first opened in 1958 whereas Faribault has been in operation for nearly a century) have meant that the geographic division is not rigid. The rate of institutional placements of the retarded in counties varies, with some counties having more than 400 placements per 100,000 population. The Owatonna State School has a statewide intake area, and its population is distributed roughly in accordance with the distribution of population in the State.[2]

Responsibility for the State institutions for the retarded in Minnesota is vested in the Medical Services Division of the State Department of Public Welfare. Within the Medical Services Division there is a Director of the Mental Retardation Program Office. The programs of learning in the state institutions are managed as a responsibility of the Rehabilitation Therapies Department and there is a Chief of this service in the Medical Services Division.[3]

Within each institution the Rehabilitation Therapies Department is administratively responsible to the Superintendent of the institution through the primary supervision of the institution's Director of Medical Services. The operation of learning programs is generally within the responsibility of the Rehabilitation Therapies Department, although some specific learning programs in some institutions are under other direction, such as that of the staff psychologist.

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[1] See Appendix A, Figure 1.
[2] See Appendix A, Figure 2.
[3] See Appendix A, Figure 3.

Organization of programs within the Department of Rehabilitation Therapies varies somewhat among the four institutions. Typically, there is a position called Instructional Supervisor. The person with this title reports directly to the Director of Rehabilitation Therapies and is responsible for varying proportions of the learning programs.[1]

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[1] See Appendix A, Tables 3 and 4.

CHAPTER V

PROGRAMS OF EDUCATION FOR THE INSTITUTIONALIZED MENTALLY RETARDED

DESCRIPTION AND FINDINGS

The population and mission of the state hospitals for the retarded, and consequently the nature of the task facing their learning programs, are in a state of change. The changes in population of the institutions are succintly described in the statistical report of the State Department of Welfare entitled, "Minnesota State Program for the Mentally Retarded, Fiscal Year 1966-67."

> Admissions of profoundly or severely retarded patients have exceeded the number of discharges and deaths among such patients in recent years. Conversely, most patients discharged from the books have been mildly or moderately retarded while relatively few admissions have been so classified. Five years ago less than 1 in every 4 patients on the books was classified as severely or profoundly retarded and almost as many were mildly retarded. On June 30, 1967 almost 2 in every 5 patients were severely or profoundly retarded and only 1 in 7 was mildly retarded. In age, patients under age 5 are seldom admitted now and very few patients under 10 are admitted while those already on the books have grown older. The number of patients age 5 or younger on the books has dropped from 65 to only 4 in the past five years. Five years ago, 1 in every 8 patients was under age 10. On June 30, 1967 only 1 in 22 was this young. Patients 65 or older have also decreased with successful placement of older patients in nursing homes in recent years.

Without dwelling upon the specifics, it will be noted that change in age and in degree of retardation characterize the population of the State institutions for the retarded. Consequently, the programs of learning in the institutions must address themselves to change.

The statistical report cited above and the other statistical reports of DPW (the monthly report of Minnesota State Institutions of June 1968, for example), could be documents useful in planning for the educational programs in the institutions. In the practical sense, however, those who are responsible for program planning must base their plans upon information readily available to them. In the matter of learning programs and related programs of rehabilitation therapies in the Minnesota institutions for the retarded, the program planners are located at the institutions themselves and there is no state-wide planning and consulting service available to the educational programs in the institutions.

The Director of Rehabilitation Therapies and the Instructional Supervisor in each of the four institutions for the mentally retarded, since they are responsible for the programs of education in each institution, were asked to furnish, from what they perceived to be appropriate and available sources, the population data upon which they based their planning.

CASE INFORMATION RETRIEVAL

The questionnaires and interviewers requested information on the age and ability characteristics of the residents. The Directors of Rehabilitation Therapies were asked to indicate the sources of their statistical information.[1] The replies were quite variable. Brainerd used the files of the administration office and the records of the medical, psychological, and social service departments. All of their population break-down figures were estimates. The comment from Brainerd was "very tedious process." Cambridge reported, "These statistics are not available here or at DPW." Owatonna reported the sources of the information to be the Child Care Office and indicated that the reported age distribution was an estimate. Owatonna reported no difficulties in obtaining the information.[1] Faribault indicated that the source of its statistical information was the Addressograph (this information retrieval system was considered by the Study Team to be creative and significant enough to warrant detailed description in Appendix B of this report), and the Faribault age and ability distributions are considered precise. As to difficulty of retrieval, Faribault commented, "We had to secure total population of hospital after which we had to insert CA and IQ (a long laborious process to say the least). This took many man hours of rehabilitation, education, social service, and psychology staff."[2] The survey questionnaire is reported by the Faribault staff to have been an impetus to the inclusion of this kind of data in the Addressograph information system. None of the reporting staff indicated that the DPW statistical reports had been used, and, with one exception, none of those questioned on the matter were aware that the Department reports existed.

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[1] See Appendix A, Table 5.

PARTICIPATION IN LEARNING PROGRAMS

Brainerd has 144 residents participating in Learning Programs at the elementary age-level, Faribault 232, Owatonna an estimated 29, and Cambridge an unspecified number. In the secondary age range, Brainerd has 315, Faribault 579, Owatonna an estimated 150, and

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[1] See Appendix A, Table 6.
[2] See Appendix A, Table 7.

Cambridge an unreported number of residents. Because of the variable definition of what constitutes a formal program of learning or instruction, the numbers of residents who participate in this kind of program cannot be reliably stated. Based on available data, however, the percentages of total hospital population which participate in programs under the supervision of the instructional supervisors are: Brainerd, 21.5%; Cambridge, 18.5%; Faribault, 20%; Owatonna, essentially 100%.[1] At the three large general institutions, most of the participants in the instructional program are enrolled for less than 2 hours per day.[2]

POPULATION FORECASTS

The Directors of Rehabilitation Therapies were asked to forecast the population trends.[3] Brainerd anticipates a decrease in total number, a substantially younger population, and one which will remain for substantially shorter periods of institutional placement than is now the case. Cambridge anticipates a decreasing population with an age distribution similar to the present and remaining in institutional placement for a somewhat shorter time. Faribault expects a decrease in total number, a slightly younger population, and one which remains in institutional placement for a substantially shorter time. Owatonna anticipates no substantial change in total population, essentially the same age distribution as at present, and a much greater number who remain in institutional placement for less than 5 years. There is fairly good agreement in these forecasts but there is also enough disagreement to highlight the fact that each educational program planner operates in some isolation from the others.

[1] See Appendix A, Table 10.
[2] See Appendix A, Table 14.
[3] See Appendix A, Tables 15, 16, 17.

PERCEPTIONS OF POTENTIALS

Since what one believes to be possible is a strong determinant of what one attempts to accomplish, the Directors of Rehabilitation Therapies and the Instructional Supervisors were asked to estimate the life potentials of their present population. Life potential was broken into three areas: occupation and economic competence, community competence, and personal satisfaction and fulfillment. Since the two respondents in each institution based their views upon somewhat different groups of residents, their estimates of potential were somewhat different. There was also a marked difference between the estimates of the different institutions. (The statistical appendix of this report should be consulted for details.)[1] Except for Faribault, the institutions consider most of their residents to have potential for at least semi-independent community competence. The potential for personal satisfaction and self fulfillment is estimated in a widely divergent manner, both within each institution and between institutions. The estimate of potential for occupation and economic competence is also highly divergent. As might be anticipated, Owatonna estimates 70% of its population to have potential for competitive employment, whereas this estimate is generally below 10% in the other institutions. Brainerd estimates a substantial proportion of its residents to be eventually capable of sheltered employment, whereas Faribault estimates most of its residents to be capable only of daytime activity (non-productive) or lower.

[1] See Appendix A, Table 18.

Some of the differences in viewpoint expressed as to the life potential of their populations appear to the Study Team to have foundation in inter-institution population differences. Other discrepancies appear to reflect the institutions' histories and philosophies as well as the relative isolation in which each institution plans its program of education and life preparation. One would expect the programs designed by each institution to reflect the differing estimates of potential. To the extent that the estimates are accurate, they influence the design of learning programs which will enable the retarded to achieve their potential. To the extent that the estimates of potential are inaccurate, the learning programs are likely to miss the mark.

ENTRY DIAGNOSIS IN LEARNING PROGRAMS

The decision to enter a given resident of an institution into a learning program is made by a "Treatment Team."[1] The extent to which the team prescribes the content of the learning program varies from the specification of the program by the treatment team, as at Brainerd, to an educational prescription made by the school personnel as at Owatonna.[2]

Diagnostic information available at the time of initial program decision typically includes medical, social, and general psychological material. Educational diagnostic procedures as such are applied almost exclusively to those who are enrolled in learning programs.[3] Very few diagnostic resources are available to the instructional program outside its own staff and none of the hospitals has educational diagnosticians other than the working instructional staff.

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[1] See Appendix C.
[2] See Appendix A, Table 19.
[3] See Appendix A, Table 20.

One of the institutions makes the comment, "Treatment teams sadly lack in the understanding and skill for this type of determination. They don't understand education."

TESTS

Tests and instruments used within the instructional departments for educational diagnosis appear to be largely limited to standard achievement tests and the customary teacher-made tests of specific content achievement. One of the institutions expresses dissatisfaction with standard achievement tests, pointing out that they are ill-adapted to use with the retarded. Faribault has devised a behavior development and adjustment scale which is now being linked to the individual student's program of learning. Brainerd has made use of the Gunzberg _Progress Assessment Chart of Social Development_ and has adapted it for use in individual program prescriptions.[1]

REPORTS

All of the institutions indicate that the central case file on each resident is routinely used by the staff of the instructional program as a reference on case information. In addition, department, section and individual staff files are reported to be in use. While the total case information is open to use by the instructional staff, the Study Team observes that the central case file is primarily designed as a medical and social service record, and is sometimes filed in a location remote from the site of the instructional program. The instructional staff makes periodic progress reports which are filed in the central case file and are additionally distributed. Oral reports and discussions are centered upon case staffings and team meetings. Reports which may be included in the central case file are limited to those approved by DPW, a circumstance which inhibits the creation of such things as, for example, prevocational trait rating scales.[1]

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[1] See Appendix A, Table 21.

INSTRUCTIONAL STAFF PATTERNS

Learning programs in the institutions for the retarded are generally administratively assigned to the Institution's Department of Rehabilitation Therapies. Some of the learning programs, but not all, are under the direction of the Instructional Supervisor.[2] The scope of the Instructional Supervisors' responsibilities differs among the institutions.

CLASSROOM TEACHING

Classroom teaching is under educational direction in all of the institutions. In some, the classrooms are set up essentially like those of public schools with students going to a standard classroom equipped with student desks and a limited amount of instructional material and equipment. In some instances other classrooms or learning spaces are distributed throughout the institution so as to provide an instructional setting in more than one building. In addition to the typical and traditional classroom teaching, some adult basic or adult life skills training is offered in the institutions which have adult residents, and driver's training is offered at Owatonna. Faribault has a teacher for the deaf retarded.[3]

[1] See Appendix A, Table 22.
[2] See Appendix A, Tables 3 and 4.
[3] See Appendix A, Tables 3 and 4.

OTHER PROFESSIONAL PERSONNEL

Industrial arts, home economics, music, speech and language therapy, and physical education are under the direction of the Instructional Supervisor in some institutions. Industrial arts and home economics are separately supervised by the Vocational Section, rather than by the Instructional Supervisor, at Cambridge and Faribault. Music is administratively located in Recreation at Cambridge and in the therapeutic section of the Rehabilitation Therapies Department at Owatonna. The speech clinicians are responsible to the paramedical services at Cambridge, to clinical therapies at Faribault, and to the therapeutic section of the Rehabilitation Therapies Department at Owatonna. None of the Instructional Supervisors have educational or vocational counselors under their direction. The librarian, in those situations where there is such a staff member, is responsible to the Institution School Principal (instructional supervisor) only at Faribault. Administrative personnel responsible to the Instructional Supervisor exist only at Faribault where the Institution School Principal has a Supervisor of the children's program and one of the adult education program.[1] A difficulty encountered in understanding the staffing patterns, especially of the kinds of personnel reported here, is the diversity of titles, duties, and administrative lines in the Minnesota institutions.

[1] See Appendix A, Tables 3 and 4.

TECHNICIANS AND AIDES

Technicians and aides are used at some institutions, with some of them attached to learning programs. Brainerd seems to have the most extensive utilization of this kind of personnel with 9 technicians (called SRST's, with approximately 2 years of college level training), 7 aides and assistants, and 4 junior college field placements under the supervision of the Instructional Supervisor. The proximity of a junior college which provides training for teacher technicians is evidently an influential factor at Brainerd. Faribault also uses a few aides trained at the junior college level. At Faribault and Cambridge, "Project Teach" also made use of large numbers of aides.[1]

COOPERATIVE VOCATIONAL REHABILITATION PROGRAMS

Brainerd has an extensive Cooperative Vocational Rehabilitation Program (CVRP) and Owatonna has a CVRP on a somewhat different scope and model. They are described in an appendix of this report. The CVRP's are concerned with learning programs but are not under the direction of the Instructional Supervisor or under the technical direction of the Department of Welfare; they are housed at the institution but are under the direction and control of the Division of Vocational Rehabilitation in the State Department of Education with the Institutions serving "housekeeping" functions.[2]

PROJECT TEACH[3]

Project Teach, where it operates, is a project funded under Public Law 89-10, the Elementary and Secondary Education Act, Title I.

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[1] See Appendix A, Tables 3 and 4.
[2] See Appendix D.
[3] See Appendix H.

At Faribault, Project Teach is under the supervision of a special Patient Program Supervisor, and is separate from the school program. At Cambridge, the situation with respect to the administrative placement of Project Teach is in flux since the position of Instructional Supervisor was vacant at the time of the study. The organizational chart does not place Project Teach in line responsibility to the Instructional Supervisor, but it is evident that the former Instructional Supervisor was influential in the operation of that program.

Aides (relatively untrained citizens from the local community employed typically on a half-time basis) are the direct service personnel of Project Teach. These personnel are commonly called "Teachers" by program supervisors. Supervision by professional staff is given, sometimes at a high level of sophistication. The focus of Project Teach is typically upon the development of ward life skills and very basic social and personal development. Though this type of development shades imperceptably into educability training and relates to the continuum of adaptive behavior skills upon which all of the learning programs focus, Project Teach appears not to have administrative linkage or good case information communication with the programs under the responsibility of the Instructional Supervisor.

OTHER LEARNING AND SUPPORTIVE SERVICES

Industrial therapy, a program which has some of the characteristics of industrial arts and some of the characteristics of vocational evaluation and work adjustment, is not administratively responsible to the Instructional Supervisor in any of the institutions. Speech and language development is responsible to the Instructional Supervisor only at Brainerd. Vocational guidance, pre-vocational training, and the graded introduction of work experience appear to the Study Team to belong on the continuum of learning programs; none of the institutions has these services administratively placed with the Instructional Supervisor.

CONSULTATION

Few consulting services from the State Department of Education have been received by the instructional departments in any of the surveyed institutions.[1] Some consultation from the State Department of Education has been available to projects such as Project Teach, but it will be recalled that most of these programs are not administratively supervised by the Instructional Supervisor.

A State Regional Consultant in Special Education has been used only recently on an informal basis by the Faribault State Hospital, and informal consultation has been obtained from the local school district special education personnel. The State Department of Welfare has no consulting service in special education or in other programs of learning.

Consultants from outside state government have not been used by the institutions other than incidental to their visits to the institutions for other purposes. The institution budgets have no funds for securing consultation.

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[1] See Appendix A, Table 23.

INSERVICE TRAINING

Inservice training of instructional staff, conducted within the past year, has ranged from a lecture on sexuality in retarded children at one institution, to a scheduled series of meetings with psychological staff and formal units on curriculum development and communication in others. The inservice training plans of the instructional sections for next year are also variable, ranging from a scheduled series of field trips for the staff to units on perceptual impairment, behavior modification, and human motivation.

There are no budget allocations to the instruction sections for inservice training other than the allocation of time within the institutional personnel structure and the provision of some transportation costs for field trips. On an individual basis, the staff of all the institutions have participated in professional meetings and conferences. The proportion of instructional staff participating in these activities varies considerably from one institution to another.[1]

Each of the institutions has made arrangements for a few site visits to other agencies serving the retarded. Travel expense is furnished from state funds. Faribault has scheduled its teachers to have two visitation days per year and requires a report back to the rest of the staff.

OTHER STAFF DEVELOPMENT

Participation of instructional staff in self improvement represented by college attendance is variable.[2] Proximity to a

[1] See Appendix A, Table 24.
[2] See Appendix A, Table 25.

college is evidently a major factor. At Cambridge, only the Director of Rehabilitation Therapies (who also functions as Instructional Supervisor while that position is vacant) has participated in college training within the past year. Teachers at other institutions have taken from two to six college credits during the year or during the summer, and three instructional technicians from the Faribault State Hospital have enrolled in college courses. There is no provision for paid educational leave or for reimbursement of educational expenses to instructional staff, nor does any of the institutions release teachers or related staff to attend college courses during working hours. Employees who attend must suffer a loss in pay or vacation time.

BUDGET AND FINANCE

There are essentially two budget lines available to the instructional departments of the state institutions. One is a personnel budget covering the salaries of positions, the other "line" consists of educational equipment and supplies. Transfer between the two major budget lines is generally not possible. The total budget for equipment and supplies in the instructional sections is astonishingly low. Cambridge, which has 277 students enrolled in instructional programs, has a budget for equipment and supplies of $600 per year. This amounts to $2.16 per year per student. Faribault with 500 students has the same budget for a per student annual expenditure of $1.20.

Federal monies are available for "Projects" only, and the institutions do not have access to the normal funding and reimbursement resources upon which public school special education programs depend so heavily. Considerable ingenuity has been shown by various institution staff in securing donations and uncommitted funds from private donors, but the amount and dependability of this resource is extremely limited, and the amount of special instructional supplies and equipment is inadequate at all institutions.

SPECIAL PROJECTS

Special projects, usually supported by grant monies originating from Federal sources, have been used by the institutions to enhance certain of their learning programs.

Project Teach is the title given by Cambridge and Faribault to their utilization of grants under Title I of the Elementary and Secondary Education Act. In this Project, approximately 239 patients at Faribault and approximately 200 at Cambridge are given intensive training in adaptive behavior and ward level life skills.

Project Teach instruction is carried out by aides generally employed on a half-time basis and recruited from the area surrounding the institutions. Cambridge has one, and Faribault has two professional staff assigned to the supervision of these aides. The professional supervisors are not under the supervision of the Instructional Supervisor but report to the Director of the Rehabilitation Therapies Department in each institution.

The conceptual structure of Project Teach at Cambridge is adapted from the Santa Barbara Individualized Diagnostic Course of Study. The aides work with groups of 3 to 6 patients and are guided by a written training prescription in each case. The primary technique used at Cambridge is a kind of behavior modification (operant conditioning), and the training is conducted in the cottages.

At Faribault, the conceptual framework is provided by the Behavior Rating Scale developed at that institution. The instructional ratio is approximately one aide per six patients. The instructional methods are eclectic, and instruction in the individual case is guided by a scale which indicates functional tasks (example, doesn't play with food) and suggested developmental tasks (example, encourage child to help set table).

At both Cambridge and Faribault, the staff reports that patients have made very substantial progress as a result of Project Teach.

Title I of the Elementary and Secondary Education Act also has been used to fund programs in summer day camping, recreation and personal development. Substantial proportions of the patients at the participating hospitals have engaged in these developmental programs.

Extension of education into the summer months, intensification of teacher-student ratios, and purchase of some instructional equipment and supplies has been accomplished on a "project basis" at Owatonna with funds from Title I of the Elementary and Secondary Education Act. In this instance, direction of the Project appears to have been the responsibility of the Instructional Supervisor. Inservice training of teachers has been included in this project.

Equipment and instructional methods appear to be substantially those typical of a special education program for the educable mentally retarded.

Title II of the same Act has been used to fund a small amount of patient library and audio-visual services at Brainerd.

Hospital Improvement Project (HIP) grants provided by the Federal Public Health Service have been used at Brainerd and Faribault for programs of learning. The Brainerd project is directed toward behavioral modification of the adult severely and profoundly retarded through habit training. Ward life skills are the major focus with the instruction carried out by psychiatric technicians under the direction of the Psychology Department.

The HIP grant at Faribault was used to develop the Rating Scale of Behavior, to devise and implement an information storage and retrieval system[1] and to relate the behavior scale to patient programming.

Manpower Development Training Act (MDTA) funds have been used through the cooperation of the institutions and the area vocational schools to train patients as Service Workers (a Civil Service classification). The State Employment Service together with the State Division of Vocational Rehabilitation selects the trainees for MDTA programs. Instruction is provided under the supervision of the area vocational-technical school. Placement on the job is the responsibility of the State Employment Service and of the Division of Vocational Rehabilitation.

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[1] See Appendix B.

Funds from the Federal Public Health Service have been used by some of the institutions for the inservice training of nurses and technicians. Some of the technician training has impact upon the learning programs of the institutions.

The Cooperative Vocational Rehabilitation Programs,[1] described elsewhere in this report, are viewed by the participating institutions as special projects. The nature of the service in the CVRP's is such that they may be reasonably classified as programs of learning. Responsibility for their conduct lies outside the administrative structure of the Department of Public Welfare.

PROGRAM REQUIREMENTS AND NEEDS

The respondents (Directors of Rehabilitation Therapies and Instructional Supervisors) to the survey were asked for their opinions of what their programs need in order to function more adequately.[2] This section of the report deals with the need as expressed by institutional personnel themselves.

Substantial increase in numbers of instructional personnel, usually specified as teachers, are seen as needed by all institutions. Other specific personnel (therapists, vocational counselors, educational psychologists, work evaluators, and technicians) are seen as needed. The Minnesota Association for Retarded Children also reflected this need in its 1969 study of institutional needs.

A greatly increased equipment and supply budget, with heavy emphasis on audio-visual equipment, is considered by most personnel to be essential to the operation of an effective program.

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[1] See Appendix D.

[2] See Appendix A, Table 26.

Space, rooms and buildings (one instructional supervisor says, "like the building at Brainerd") are considered high priority requirements.

All institutions mention need for regular help from outside consultants in human learning and special education, a budget and other enablements for effective inservice staff training, and a system of encouragement and incentives for self improvement.

The reporting institution staffs also indicate need for program changes. Among the needs frequently mentioned is a shift from stereotyped programming, around the supposition that the institution residents are all deficient in intellect and incapable of learning life adaptive skills, to an approach to which is more akin to the Psycho-Educational approach to learning. In this concept, a person who experiences difficulty in learning the adaptive behavior which life requires is first of all considered as having a reason for his maladaptation and a need for educational diagnosis, educational treatment, and circumvention, where possible, of specific functional disabilities. This concept is seen as one which promotes a more progressive program than does the concept which tends to label residents of the institutions as simply "dumb people who can't profit from learning programs anyway."

Several of the institutions report an interest in developing a conceptual framework in which they can cast the design of their learning programs. In this framework, concrete life skills would determine the purpose and content of the learning programs as well as the kinds of things which would be measured and monitored to evaluate the individual student's progress. Such a conceptual framework does not now exist, except that some of the institutional staff are taking some initial steps to develop this framework.

At Faribault, the behavior development and adjustment schedule has been linked to an information system which will now be tied to individual student programming. At Brainerd, a modification of the Gunzburg Social Education First Aide Teaching Program is in the process of development.

There is little linking up of these efforts across institution boundaries, however, and quite often the department and section boundaries within the institutions are impermeable to communication on this subject.

Several of the institution staff report that communication across department and section divisions is difficult. The reorganization of the larger institutions into treatment units (almost a division into sub-hospitals) is an attempt to make for better coordination of the individual resident's program. Even this, however, is seen by some of the therapy and instruction personnel as being an inadequate step. The observation that other team members do not understand learning programs and yet are responsible for program prescription has already been cited. Another observation is that "This institution and the department have to see special education as a more vital part of the ongoing program," a comment prompted by a discussion of the budget made available for education and the fraction-day learning programs in which only a fifth of the hospitals' residents participate.

Greater budget flexibility is stated as a need by the instructional staff, so that equipment and supplies can be purchased sooner. A cash revolving fund or a petty cash expenditure fund is also suggested. Instructional staff point out their text books and supplies are often obtained as gifts from school systems which consider them to be obsolete. Institution staff members indicate that they need more up-to-date and more appropriate materials and supplies, in substantially increased quantity, than they can now secure.

An adequate, functional information system is seen as needed by the Rehabilitation Therapies Directors and Instructional Supervisors. Until population descriptions were requested in this survey, some were not aware that they did not have population descriptions upon which to base program plans. Faribault states that the survey was an impetus to the inclusion of program and program prescriptive data in their Addressograph system (the survey team feels that this creative step by the Faribault staff at least partially compensates for the labor required by the questionnaire). Faribault points out that its information retrieval hardware has enough surplus capability so that it could potentially serve the case information needs of the other institutions as well.

STUDY TEAM COMMENTS

Woodrow Wilson once defined golf as "an ineffectual attempt to place an elusive ball into an obscure hole with the aid of tools ill adapted to the purpose." While the study team is deeply impressed with the skill, resourcefulness, energy, and dedication of most of the instituion staff involved in learning programs, it is clear that organizational structure, funding, and sometimes conceptual frameworks in the institutional system are tools which are ill adapted to the purpose of learning.

Those who are responsible for the planning and conduct of learning programs often do not have the demographic information which would permit planning of more adequate programs. A minority of the institution residents participate in learning programs, and this minority participates for an average of less than 2 hours per day. These facts are certainly related to the administrative placement of learning programs. They have generally been placed as a subsidiary portion of a therapy department developed late in the history of institutional systems. These systems have been traditionally conceived of as hospitals for the management of people who had no capacity to progress.

The learning programs in these institutions are equipped with inadequate diagnostic and supportive resources. Technological development in the learning programs is inhibited by the lack of organizational options for consultation, training, and program analysis. Perhaps the most telling commentary upon the importance accorded learning programs by the political-organizational structure is the allocation of an annual budget for instructional materials and supplies of $600 in an institution housing almost 1500 persons.

Resourcefulness has been shown in securing and using grant monies for programs of learning. These projects, however, are typically operated in organizational isolation from the instructional programs of the institutions, and the difficulty in communicating case action and technological improvement across department lines has been remarked upon by both the institutional staffs and the Study Team. Since many of the projects are intended to serve the purpose of demonstration and innovation, their "foreign body" nature raises serious questions to the capability of the institution to incorporate the demonstrations into ongoing funding and operation.

In addition, grants and "Project" funds are useful primarily on a temporary basis, and for innovation and demonstration. They are not a substitute for adequate basic funding, nor is it likely that they provide programs of the size which is needed. Mention in this report of possible funding resources should be interpreted in that light.

CHAPTER VI

RECOMMENDATIONS FOR PROGRESS

Commentary - Faribault, Cambridge, Brainerd*

As outlined in Chapter I, the major recommendations made by this study are organized into four major categories. These categories and recommendations will be restated in this chapter, and will be supported with background information, related findings and conclusions, and, in many cases, suggestions for implementation.

Again, these recommendations relate primarily to changes in attitude, priority, support systems, philosophy, other agency involvement, needed programs, scope of service and facilitating of change. Although the study team gathered enough information and impressions to formulate recommendations dealing with program specifics within each institution, and to recommend some very specific technical and operational changes for these learning programs, or to recommend specific types of aduio-visual equipment, such recommendations would be essentially irrelevant to the stated objective of improving learning opportunities for all institutionalized mentally retarded persons.

It is clear to the study team that the basic problem which now limits both the quantity and quality of learning progress for the institutionalized mentally retarded is not a mechanical, a funding, or a curriculum problem. The problem lies in the conceptualization of institutionalized mentally retarded persons as in

*for comment regarding Owatonna State School, see page 78.

need only of care and treatment, with only token priority given to improving adaptive behavior. It is clear that the clinical treatment model, as exemplified by current practices in all four institutions, is conceptually inadequate to the task of significantly improving adaption behavior to individuals. Dr. Seymour Sarason in an unpublished paper, speaks of the need for a major reconceptualization.

> "The new problem would be difficult enough if only new settings were involved. However, as Blatt and Kaplan (1966) demonstrated in their photographic essay, Christmas in Purgatory, we are also faced with the problem of how to change settings which no longer are consistent with their stated purposes and, let us not forget, debasing of all concerned.
>
> "The conditions described by Blatt and Kaplan, those described by many in regards to our urban schools, those that exist in many of our state mental hospitals--in these and other settings their self-defeating characteristics can in large measure be traced back to characteristics of the beginning context. That is certainly not the whole story, but is an important part of it and one which has not received attention. However, we cannot see the problem until we first recognize that the creation of a setting (or the repair of a sick one) is not a clinical problem, or one which is contained in or derivable from theories of individuals or individual personality, or a communication problem which is solvable by legislating talk, or an administrative problem requiring refinement of organizational charts, or a problem requiring motivation, good will, and abundant energy. The problem requires a way of thinking and conceiving which recognize the existence, characteristics, and dynamics of social systems and structures; the consequences of these for stating and choosing alternatives for planning and action; and the development of means and vehicles from the beginning so that eyes will see, ears will hear, and minds will face the evidence before them.

> "...If this problem is not recognized and studied we will continue to confuse action with progress, programs with accomplishment, the expenditure of money with improvement, and the failure of a setting with bad luck or the obtuseness and evil of individuals...settings misfire in the same way that so much research misfires: the conceptualizations which generate the creation of settings are either oversimplified, fuzzy, or simply wrong."

Traditionally, Minnesota's Institutions for the Mentally Retarded have been conceived of and have been operated like "Hospitals." It seems clear to Study Staff that this conceptual and operational "set" is not the most effective one in terms of meeting the adaptive behavior or learning programs needs of mentally retarded children and adults.

In order to improve both the capacity and the quality of programs of learning in our State Institutions for the mentally retarded, a much higher priority is needed for development of a conceptual model compatible with establishing an environment for learning is needed. At the present time, staff allocations are completely inadequate, and funds for consultation, program planning and for the necessary learning tools are either non-existant or at subsistence level. Program visibility for purposes of competing with other departments within the institution for priority and for funding is limited. Inservice training opportunities for existing staff are limited, and civil service policies tend to discourage personnel for attending late afternoon college courses. The programs have had little or no consultation or guidance from either personnel of the State Department of Welfare or the State Department of Education. With a few exceptions, there are few formal contacts with the local educational agency, and none seem to be planned. With the exception of Owatonna, no institution is serving more than 25% of its residents in its regular programs of instruction; and most of these receive instruction for one-quarter day or less. Patient work in the institutions was generally not capitalized on as an opportunity for improving functional personal or work skills, and is used primarily for purposes of running daily institutions operations. Only a very small number of residents receive any formal work adjustment training. Sheltered employment is almost non-existent for the institutionalized mentally retarded. The "treatment team" approach is quite cumbersome and inadequate as a mechanism for improving adaptive behavior, however adequate it might be for sorting out and assigning residents to various "programs" or "therapies."

Certainly the developments of the past few years hold some promise for change. The development of community level services for the mentally retarded is to be applauded and encouraged. The dedication of P. L. 89-10, Elementary and Secondary Education Act funds to institutions has resulted in a number of quality improvements in instructional programs within these institutions. "Project Teach" is one outstanding example. The movements within each institution to take learning programs to the wards rather than concentrating resources in a "school" building is also encouraging, and should be continued. The concern that too many mentally retarded were being institutionalized unnecessarily has resulted in an encouraging decline in institutional populations. The recent emphasis on the legal and human rights of institutionalized persons, along with the attempt to eliminate dehumanizing aspects of patient life has focused attention or heretofore ignored patient abilities. The Foster Grandparent Program and other volunteer efforts promise to make institutional life more pleasant and human.

While these trends and programs are encouraging, we must not lose sight of the fact that the task of developing the human potential of the institutionalized mentally retarded is monumental. Increased staffing of aides, nursing personnel, and others interested in improving the daily care and affective environment for residents is necessary to negate the regressive effects of the typical institution, but are not sufficient in and of themselves to improve significantly the adaptive ability of a retarded individual. An intensive, formal, and well-defined program of teaching and learning is necessary to capitalize on the abilities of a particular patient, whether the goal is to make him more productive and self-sufficient in the institutional environment or in some broader social setting. Until this opportunity is securely available to every institutionalized retarded person, and until current programs of learning are given more support for quality definition, most of the institutionalized mentally retarded will continue to be disenfranchised citizens who are being protected and contained, but who have no opportunity to improve their level of functioning.

It is clear that Minnesota's Institutions for the Mentally Retarded are not meeting the learning needs of at least 75% of the institutionalized mentally retarded. Part of the answer lies in preventing institutionalization through development of effective community level resources, as the ability of large Welfare Institutions to adapt to individual differences is low. Part of the answer also lies in making serious attempts to upgrade both the quality and quantity of structured learning opportunities available to those who will need to be, or who currently are, institutionalized. The recommendations which follow, and which were stated in summary form in Chapter I, attempt to address to both dimensions. These recommendations should certainly not be considered all-inclusive, but they do provide a starting point for discussion and implementation by responsible officials and interested citizens. For purpose of definition, "Learning Programs" as used in the following recommendations refers to any organized attempt to modify a person's adaptive behavior, regardless of the severity of the handicap or the age of the person, and includes but is not limited to the more traditional programs of the academic skill learnings.

RECOMMENDATIONS

A. RECOMMENDATIONS GERMANE TO THE TOTAL WELFARE INSTITUTIONAL SYSTEM FOR MENTALLY RETARDED CHILDREN AND ADULTS.*

Recommendation 1

A system of smaller residential care facilities should be located throughout the state according to population density and characteristics. Placement in large institutions removed from proximity to home and community, where scarce and expensive resources would have to be pooled, should then be reserved for those few individuals whose physical and medical needs are too great to be met through local or regional programs, and whose organic condition is so poor that complete custodial and nursing care will be needed on a long term basis. Facilities now available at the community level should be used with more regularity, rather than being ruled out primarily on the basis of cost to the county.

Related Findings and Rationale:

a) Although a number of local care facilities exist throughout the state, and although additional resources could be developed, there is evidence that 1) local Departments of Public Welfare and their case work agents have generally not made adequate use of the diagnostic and service potential available at the local or regional level and, 2) many institutional referrals have been made more on the basis of local cost of care factors than on the clear need for placement in a large State Institution.

b) Evidence indicates that optimum daily care and affective environments are more readily provided in smaller residential settings. It is clear that these environments must be adequate if formal programs of learning are to be effective.

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*See Chapter 1, page 1 for qualifying statement regarding this category of Recommendations.

Implementation:

Although the study team considers placement decisions made primarily for reasons of cost of care savings to the county to be in violation of a number of ethical principles, many placements have been made on this basis. To eliminate decisions based on cost-of-care, we recommend the development of a cost-of-care bill which would equalize costs to counties if local special facilities are used rather than the less expensive (to the county) State Institutions. We think this would be the most direct and effective way of eliminating this pernicious practice.

Recommendation 2

For those individuals who can be served in smaller residential facilities, the major program and administrative elements of these facilities should be determined by the learning and life adjustment needs of the residents.

Related Findings and Rationale:

a) Mental retardation is not a disease, but is rather a condition of sub-average intellectual functioning and impairment of adaptive capacity below normal expectations.

b) Although adaptive behavior in some cases can be modified by medication or other organic intervention strategies, it is more likely to be affected by a formal program of strategies based on the notion that behavior is learned, and that a structured learning environment can significantly modify behavior. Medical management is useful in many cases (re: Drug therapy, special surgical techniques, etc.), but should be considered as supportive to the primary mission of creating and maintaining an effective learning environment.

c) Nursing and medical personnel generally are not trained in the creation and implementation of structured and effective strategies designed to assist children and adults in improving adaptive ability. Their skills are most effectively used wherever medical management is necessary, rather than in roles which require them to make learning program decisions.

d) Most local care facilities have major care, custodial, and recreation elements. However, few have given major attention to the learning needs of their residents.

Implementation:

Since cost to counties for private facilities is already higher than that for a State institution, and since a significant cost would result from designing local care programs to meet the learning needs of each resident effectively, any redesigning or requirement for new local facilities will, for practical reasons, have to wait until cost of care is no longer a significant factor to the counties. When this happens, licensing regulations for local care facilities should be strengthened to reflect the philosophy that, beyond adequate housing and attention to basic physical needs, the primary priority should be provision for meeting the learning needs of the residents.

Recommendation 3

The present system of making decisions regarding institutionalization should more specifically include, in addition to specialists in welfare, family status, medicine and law, specialists skilled in learning and behavior development areas. The concept of a regional or county inter-agency clearinghouse for case management of handicapped persons should be explored and considered.

Related Findings and Rationale:

a) Public schools in many areas of Minnesota are more able to provide services to handicapped children than in previous years. Advent of federal funds, cooperative organizations of small districts for special services, deployment of Regional State Department of Education consultants to out-state areas, and employment of local specialized leadership personnel have begun to strengthen the schools' potential for determining which service patterns should be provided for school-age handicapped children.

b) Local Welfare case work personnel seem to have no consistent method for involving people knowledgeable about day care or educational options which might exist or could be developed to keep a child in the community. In making decisions about institutionalization, there is often only minimal articulation with local resources and the decision is often made without the participation of other community agents.

Implementation:

Regional Department of Education Special Education Consultants and local supervisors, where available, should be routinely involved in welfare decisions about placements of handicapped children.

Also, establishment of an inter-agency of regional clearinghouse for handicapped persons whould be explored for purposes of inter-agency case information storage and retrieval, and for purposes of insuring consideration of all local and area options before sending a person to a State Institution.

B. RECOMMENDATIONS GERMANE TO THE RESPONSIBILITY AND OPERATIONS OF THE STATE EDUCATIONAL SYSTEM.

Recommendation 1

Programs designed to meet the learning needs of the mentally retarded should be under the administrative, technical, and financial regulation and support of the State Department of Education. Persons who reside in state institutions should not be considered exceptions to the general policy of having educational responsibility lodged in the State Department of Education. The legal mechanism for maintaining State Education Agency responsibility for learning services to the institutionalized mentally retarded should be the local public educational agency.

Related Findings and Rationale:

a) Under existing law, the State Department of Education, acting as agent for the State Board of Education, is responsible for providing suitable educational experiences for Minnesota's school age citizens.

b) The Department of Education has the technical leadership, the administrative machinery, and access to the funding sources necessary to establish and maintain programs of learning for the institutionalized mentally retarded. The Department of Public Welfare has none of these.

c) Most children and adults living in State Institutions for the Mentally Retarded are not receiving special instruction and services, and are literally disenfranchised from their right, as citizens, to an education.

d) The 1957 Special Education Laws, and the 1965 Residency law produce this disenfranchisement by discriminating against school age persons who live in State Institutions for the Mentally Retarded. The '57 laws by excluding "trainable" retarded children from the mandatory provisions of the law, and the Residency law by excusing school districts from fiscal responsibility for educational costs for children living in State Institutions. See Appendix E for copies of these laws.

e) The Study Team believes that persons "classified" as mentally retarded who reside in State Institutions should be considered citizens in possession of those constitutional and civil rights guaranteed each of us, and which are consistent with the Public Safety. Existence of a handicapping condition which limits functional ability, and locus of residence should not be criteria for disenfranchising any person from these rights.

f) The State Department of Education has made no significant attempt to take responsibility for meeting the learning needs of the institutionalized mentally retarded. This has been largely because all operations of State Institutions for the mentally retarded, including their programs of learning, are under the administrative and legal control of the State Department of Public Welfare.

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Implementation:

The 1957 Special Education laws should be amended to make provision of special education and services mandatory to handicapped children regardless of judgments regarding degree of handicap. The category of "trainable" is an artifact created 11 years ago when legislators and educators were less knowledgeable concerning mental retardation than they are now.

The 1965 Residency law for handicapped children should be amended to assign fiscal responsibility for provision of learning programs to the school district where the parents live, and program responsibility to the District in which the Institution is located.

A cooperative plan should be designed which would give responsibility to the Local Educational Agency for leadership, administration and supervision, and fiscal aspects of the operation of learning programs in these State Institutions, with custodial, daily care, medical care, and related medical therapies remaining the line responsibility of the Department of Public Welfare. This arrangement, whether legislated or contracted between agencies, would broaden the funding base and would place the respective agencies in their appropriate roles.

See Recommendation Category "D" (further study), Recommendation #1 for further background and suggestions.

Recommendation #1, Category "C" also pertains to implementation of this recommendation.

C. RECOMMENDATIONS GERMANE TO THE OPERATION OF THE LEARNING PROGRAMS IN THE VARIOUS INSTITUTIONS FOR THE MENTALLY RETARDED.

Recommendation 1

A full-time state level consultant in educational programs for the institutionalized mentally retarded should be employed and assigned to work with the various institutions on development of quality programs for learning.

Related Findings and Rationale:

a) Supervisory and direct service staff in the learning programs need assistance in defining objectives, in designing curriculum, in selection and use of appropriate specialized materials and equipment, in cross-communications with other school district and institutional programs of learning, and in application of new technologies.

b) These personnel now have access to practically no consistent and well-defined educational consultation. Neither the Department of Welfare nor the Department of Education has provided this type of assistance.

c) Only minimal local public school involvement with institution education programs was reported. A consultant, particularly if employed and assigned by the Department of Education, could be very helpful in bridging this involvement gap.

Implementation:

The Department of Education should employ a Special Education Consultant to provide assistance for the development of quality programs of learning in the institutions for the mentally retarded, and to assist in the further definition and implementation of the recommendations contained in this Report. This professional should be considered an integral part of the State Special Education Section as the implications for eventual (State and Local Educational Agencies) funding and operation of these programs of learning are many, and would be enhanced by this suggested administrative placement.

Funding for this position could come from one of at least three sources, or a combination of two. Title I, P. L. 89-10 funds specified for educational programs in Institutions would be one source. A Title VI, P. L. 89-10, State Initiated Project would be another. A combination of these two would also be worth considering. Assignment of a Department of Education staff position could also be a possibility. However, if this consultant is to be employed, he should begin as soon as possible - either this summer or fall of 1969. For this reason, the latter funding possibility might not be appropriate unless funds could be freed for this position by September, 1969.

Recommendation 2

Comprehensive in-service training experiences of all types designed specifically to support staff assigned to programs of learning should be given major priority, direction, and support by both State and institutional level leadership personnel.

Related Findings and Rationale:

a) Some attempts have been made by Supervisory personnel to initiate and conduct in-service or staff development programs.

b) These efforts have generally been poorly funded and supported, and need to be related to some consistent philosophical and operational framework.

c) Individual attempts to keep up with the "field" through formal course work at State Colleges or at the University of Minnesota have been made, but are inhibited by an inflexibly defined work day for staff. As these institutions are some distance from colleges, personnel taking late afternoon course work must leave generally by mid-afternoon. As the Study Team understands the situation, the employee must 1) use vacation hours or 2) suffer a reduction in pay for the one or two hours he would miss, even if the course is directly related to improving the person's professional competencies.

d) The rapid growth of technologies and specialized materials related to learning programs, as well as the changing nature of the institutional population, requires that learning programs personnel, both professional and para-professional, be constantly involved in a program designed to maintain and increase their competencies. No one institution currently has an effective system for accomplishing this.

Implementation:

The concepts inherent in individually prescribed instruction (educational-functional diagnosis, desired changes defined in behavioral terms and related to specific criterion performance levels, an educational or adaptive behavior prescription, adaptation of techniques and materials to carry out that prescription, etc.) would be a most suitable topic for extensive in-service training of all staff. Teachers and staff who work in these institutions do not really need to know how to teach formal reading or other basic skill subjects. These are just not appropriate goals for 90-95% of current residents. This will be even more true if current population trends continue. Staff does need to know, however, how to define and write specific objectives related to the learning and adjustment of any one individual retarded resident. They also need to know how to carry out the stated objectives, and need to be thinking constantly of behaviors, rather than curriculum areas.

Most teachers of the retarded have not had training appropriate to these objectives; hence, a system of staff development should be structured to assist staff. Department of Public Welfare funds, Hospital Improvement Project (HIP) funds, or Title I, P. L. 89-10 funds could be used for this purpose in the institutions. However funded, development of a formal staff education system should have high priority. Also, it may be possible to design some in-service approaches and mechanisims standardized for all institutions. At the present time, each institution is "on its own," and funding or personnel energies are not being effectively used.

Recommendation 3

Programs designed to meet learning and life adjustment needs of the institutionalized mentally retarded should be given a much higher priority for support than now exists and should be administratively designed to facilitate the provision of quality programs of learning for all residents. These programs should be considered a major focus of the institutional program for all residents, and should be expanded accordingly.

Related Findings and Rationale:

a) 75% of the residents of Brainerd, Faribault and Cambridge are not engaged in any formal program of learning; and the 20-25% who are, are enrolled only part-time.

b) Learning Programs are seriously under-staffed, even for the 25% they are now serving.

c) The mechanism or process of achieving priority for budget for learning program personnel and support items is cumbersome, and is subject to routine reduction by personnel who do not fully understand the role of learning programs personnel as compared with nursing, therapy, and other medical professional disciplines, and is related to legislative appropriations every two years. The budgets for learning programs in these institutions do not reflect adaptability or flexibility, and often act as a brake to staff creativity in meeting the learning needs of the residents.

d) Administratively, the learning programs in institutions are seen as some type of "therapy," as evidenced by the fact that line supervision for all of these programs is the responsibility of the Director of Rehabilitation

Therapies. Programs of learning have limited visibility within this framework, and this lack of visibility impairs ability to be effective in expanding to meet the needs of additional residents, or to better meet the needs of those persons now being served. While the leadership of those individuals who currently act as Directors of Rehabilitation Therapies is evident in current programs, learning programs are generally perceived in a limited and restricted manner by institutional personnel at all levels. A comprehensive re-thinking of the role of the learning programs and their administration within institutions is advisable.

Implementation:

Ideally, the local educational agency should provide the administration, leadership, budgets, and other related variables for these learning programs. Much of the difficulty now lies in the welfare budget system which is directly dependent on the every-other-year session of the legislature. Monies earmarked for programs of learning must run the gauntlet of welfare priorities before any becomes available for actual program operation. Education of learning programs operation is only one of the priorities for the Welfare-Institutional System. It is the only priority for the State Department of Education and for the local educational agency. In addition many federal, state, and local funding sources are available to the local public school which are not directly or readily available through the Welfare Administration. Titles II, III, and VI of the Elementary and Secondary Education Act, as well as the 1968 Amendments to the Vocational Education Act are examples. Also, State Special Education aids are not available - this is a considerable loss and is a deterrent to program growth.

Learning programs need to be supervised, administered, staffed, and financed by those agencies who are full-time at the business of education and should be managed separately from the other multiple problems of funding and priority setting which a large State Welfare Institutional System must use. Admittedly, this would be no small undertaking! Many persons would be affected, and transition would be difficult. Clear definition of role and function of each agency would need to be made, and important legal factors clarified.

We do not, however, in spite of the trauma and difficulty associated with transfer of the major responsibilities for programs of learning, believe that it is impossible. Many items and questions would have to be clarified, and a transfer of responsibility would not occur overnight. For these reasons and others, we can only indicate as implementation Recommendation #2 of Category "D", Recommendations for Further Study. More information is needed, and persons will have to be involved who were not seen or involved by this Study Staff. Additional concrete data regarding costs, legal problems, etc. will be needed, and are not available without further study.

If programs of learning in the institutions for the mentally retarded are ever to be highly effective and visible, as well as available to most institution residents, these programs will have to be cast into the funding, administrative, and philosophical mainstream of public education for handicapped persons.

In conjunction with the above, "Education" has to be re-defined by the State Department of Education in order to appropriately meet the needs of the institutionalized mentally retarded, as has already occurred to some extent in a number of public school programs for more severely retarded children.

Recommendation 4

The beginning efforts of some institutions to extend formal programs of learning to all corners of the institution and community should be encouraged and expanded.

Related Findings and Rationale:

a) Faribault, Cambridge, and Brainerd are all beginning to expand learning program services to the wards and other living areas of the institutions.

b) This movement is consistent with population trends as related to the defined life needs of the residents.

c) Education for basic and functional life skills is most appropriately taught in real-life daily activity settings.

d) Other personnel (nursing, ward aides, etc.) can more appropriately comprehend the learning process if learning programs staff are working with children and adults "on the scene."

e) "Project Teach" is an excellent example of this effort. So is the ward level program at Brainerd. However, a serious problem limiting the application of this concept is the lack of suitable facilities and space in the living areas.

f) The patient population trends harbinger a move away from the typical "trainable" class activities now prevalant in institutions. Learning activities will, in the future, be geared to help individuals in learning to adapt to the demands of their daily environment and to learn basic body functions and perceptions. The current trend to decentralize learning programs to all corners of the institutions is an important step.

Implementation:

Continue this emphasis. Refine "Project Teach" operations and expand to many more residents (this will require additional staff, as current "Project Teach" staff already attempt to serve too many residents with some loss of impact on each resident included). Train ward level personnel in techniques of behavior modification and reinforcement principles, and place them under appropriate supervision. Examine very carefully any request to expand "centralized" facilities for housing learning programs. With some exceptions, priority should be given to providing space, equipment, and other support necessary to maintain ward level learning activities. HIP Grant funding could be used to train ward level workers as mentioned above. For wards containing a high number of patients 16 years and older, the possibility of funding, for example, through the Vocational Rehabilitation Facilities Construction Act should be explored with the State Division of Vocational Rehabilitation.

Recommendation 5

Vocational evaluation, work adjustment, and pre-vocational training should be major and integral components of each institution's program of learning and should be more closely coordinated with the other formal program components.

Related Findings and Rationale:

a) Program offerings of this type are few in number and lack sophistication when compared with available technology.

b) The Cooperative School Rehabilitation Program (CVRP) holds some promise for development of these services, but has not yet been adequately demonstrated as a model for the design and vending of vocational evaluation, work adjusting, and pre-vocational training in institutions. See the Appendix for a full description of this model and for other comments relative to its current status in the institutions.

c) The institutional setting has much potential for using various real work activities as stations for work evaluation and adjustment. Most work placements, however, are not treated as opportunities for learning or for evaluation, but are primarily treated as help necessary to run the day to day affairs of institutional life.

d) These programs are under staffed and serve only a token number of residents. The success during the past few years in returning patients to the community speaks well for efforts of these staff, and clearly calls for expansion and refinement of these programs.

Implementation:

Add more trained staff. More clearly define administrative and program relationship to other programs of learning. Concentrate on demonstrating the CVRP model in one or two settings (Brainerd has a good start) and expand to other institutions only after efficacy is demonstrated. Discuss with area Directors of Vocational Education or with the State Office of Vocational Education regarding possible funding and/or cooperative agreements.

Recommendation 6

A formal information system designed to monitor individual potential, progress, and outcome in learning and life adjustment should be established, and should be linked to a more effective program communication network in each institution.

Related Findings and Rationale:

a) Information related to the educational functioning or the learning prognosis or condition of each resident is generally not available. Patient files reflect social and family data, medical diagnostic and treatment information, and patient history since being institutionalized. This information is interesting and sometimes helpful to learning programs staff, but is not very directly related to the type of information required to carry out a program of learning for a given resident.

b) The difficulty experienced by learning programs staff in gathering data necessary to this study reflected an inadequate information processing and retrieval system.

c) The recent information system established by Faribault contributes more to the information needs of learning programs staff than any system in operation in the other institutions.

d) Information systems should be designed to aid in 1) both administrative and program planning and 2) in the identification and monitoring of patient progress. With the exception of the design projected by Faribault, there were no information systems that satisfied either of these requirements. The Faribault design is outlined in the Appendix.

Implementation:

The Faribault system should serve as a beginning model. Other institutions should study this model, and consider it for use in their learning programs operations. The Faribault system should be expanded and refined, with eventual application to a data processing operation for more immediate processing and retrieval. The present manual system, however, should be maintained until the "wrinkles" are worked out of the model.

More information on developmental life-skills of individual patients should be available to staff. The learning programs staff showed interest in this type of information, and have already begun searching for means of collecting and using this information. Project Teach and a few other program elements are now doing this best, and this direction should be encouraged. This is one of the areas where much staff in-service is needed, and where the various institutions could benefit by sharing and working together.

Recommendation 7

Diagnostic services available to the learning programs staff should be expanded to include the services of an educational psychologist skilled in psycho-educational assessment and remediation processes.

Related Findings and Rationale:

a) Psychological services available to program staff were generally "clinical" in nature. These services are necessary, but need to be supplemented by the services of an educational psychologist skilled in psycho-educational assessment techniques and remediation processes. This would be an important link in supporting learning programs staff in any attempt to define objectives and construct individual learning program prescriptions.

b) Teachers and other learning programs staff are often unable to translate psychological reports and other clinical information into practices designed to improve adaptive behavior. A qualified educational psychologist could be helpful to staff in this respect.

Implementation:

Since Civil Service Salary Scales for Psychologists probably could not attract and retain a highly qualified person, services might have to be contracted from either a private educational psychologist from a school district, or from one of the Mental Health Centers that retain and vend the services of educational psychologists. Again, local public schools generally have more flexibility in this regard.

For those institutions that already have significant service from a staff clinical psychologist, two or three days a week of service from an educational psychologist might be sufficient. The distance of most institutions from the Metropolitan area will not be very helpful, as there is more availability of these personnel in the major population areas. The various institutions might consider sharing a full-time person with their local educational agency. If a school system employs a psychologist, the cost is markedly reduced because of the availability of state special education aids. A local school district could also sponsor a Title VI, ESEA proposal for shared services. Title I, ESEA, could also be considered as a potential funding source.

Recommendation 8

The use of para-professional personnel in support of programs for learning, as observed in some institutions, should be encouraged and expanded.

Related Findings and Rationale:

a) There will probably never be available enough BA or MA special education teachers to provide learning program services to all residents of the institutions.

b) Evidence is clear that personnel who may not have specialized training to work with the handicapped, and who may not be certifiable as "teachers" can be trained on the job to be effective in complementing the fully trained teacher. Housewives from the community, Junior College graduates, practical nurses, etc. can be utilized with good pay-off. Project Teach, again, has helped demonstrate this. Also the program at Brainerd, both in the in-school and ward-level applications, has been able to demonstrate the effective use of para-professional personnel.

c) Teachers and other highly trained personnel were observed to perform many necessary tasks which could have been done by a teacher aide or by a child management aide. This represents inefficient use of valuable professional services.

d) A larger number of residents could be provided constructive learning experiences at much lower cost by using many of the already-employed trained teachers now employed as leadership persons with responsibilities for training and supervising four to six (or more) para-professionals, who in turn would be responsible for a certain number of children or adults.

c) Some of the fully-trained professionals currently employed would not desire or be competent to accept a role such as this.

Implementation:

Funds available for learning programs staff vacancies or for new positions should be used to employ additional teacher aides or child management aides, with the objective of extending the reach of carefully selected professionals to more residents. The Brainerd model may be worth looking at in detail by the other institutions.

Professional staff selected for this role should be provided with guidelines and with intensive in-service training relating to use, training, and supervision of these para-professionals.

New professional staff assigned to institutional learning programs should be employed with the expectation that their role will not be that of the traditional special class teacher, but will be as described above. Selection criteria for screening of new applicants should reflect concentration on traits which might indicate success at working with para-professionals.

A formal program of in-service training for para-professionals is essential if this effort is to have efficiency. This training should concentrate on use of reinforcement techniques, understanding of developmental norms, introduction to the implications of the most common physical and medical problems encountered, the importance of multi-sensory training techniques, etc.

Recommendation 9

A special task force of program consultants should be sent to each institution on a regular basis (1 to 2 days a month) to assist with the difficult problems of upgrading learning programs, and to assist with implementation of the recommendations contained in this Report.

Related Findings and Rationale:

a) All recommendations in this category (category C) are based on needs as stated by institutional personnel and by the Study Staff.

b) A statement of needs is not sufficient. Implementation of recommendations must be given priority if improvements in the learning programs are to occur.

c) Program improvements will occur in some ratio to the amount of creative energy devoted to redesigning systems and to operationalizing recommendations. Certainly existing learning programs staff can be expected to carry the major responsibility in this respect. These personnel, however, are already intricately involved in the day to day operation of service programs, and will need knowledgeable external support, information, and guidance if major focus is to be given to implementation of key recommendations. It is clear that a group of special consultants could be effective as catalysts for continued program improvement.

Implementation:

A number of major program improvement directions seem clear -- use of para-professionals, use of objectives defined in functional, behavioral terms, development of an adequate information processing and retrieval system, etc. Specialists in one or more of these areas should be employed to assist, on an ad hoc basis, with the implementation of specific, high priority, recommendations. A number of extremely knowledgeable individuals in university, state college, public school, and in private and public agencies would be available. Program consultants, however, should be asked to 1) devote their attentions to very specific items (how to help staff learn to write and use specific objectives defined in behavioral terms, for example) and 2) generally attempt to add to the competencies of leadership staff assigned to learning programs.

Two days per calender month of specific consultation per institution would represent the minimum amount one could expect to provide and still achieve results. If possible, consultants should be assigned in teams of persons with related competencies, with two consultants per team. Although estimated cost would be $12-1500 per month, the expenditure of funds in this manner would be more productive than would the equivalent (in dollars) addition of one or two teachers to one of the institutions. Clearly, the total answer is not more of the same.

Two other points are important. First, this type of consultant service should not be provided at the sacrifice of the full-time consultant position recommended on page 54. Secondly, this service should not be provided for Owatonna State School at this time, but should concentrate on Faribault, Cambridge, and Brainerd.

Recommendation 10

Workshops offering long-term sheltered employment should be established to serve clients from both the institution and the community area. These workshops should be located off the grounds of the institution.

Related Findings and Rationale:

a) Institutional sheltered work is usually provided only for the more capable residents, and relatively little organized guidance is given to designing these work experiences as learning opportunities. Many residents have no access to any form of meaningful work activity.

b) A number of possible developments at the State Level may hold some promise for development and support of these terminal sheltered workshops. One of these is the legislative attempt to increase the aid available for financial support of this type of sheltered workshop. Another is the development of a central clearinghouse for locating and assigning, on a state-wide basis, of sub-contract work available. Under this system, specific sub-contracts more relevant to terminal shops would be more easily located.

c) None of the communities in which institutions for the mentally retarded are located have sheltered workshops available. In each of these communities and surrounding areas however, there are a number of persons who could be employed in a sheltered work setting. It would seem logical to establish one area-wide sheltered shop to serve the needs of both community and institutional populations. If established, however, it is felt that the workshop should be located off the grounds of the institution. Although this would create transportation problems for the institution, the importance of "going somewhere" for work, and the fact that an institutional location may result in feelings of disassociation on the part of the community, are not to be minimized.

Implementation:

Institutional and community persons interested in pursuing this recommendation should make formal contact with the State Division of Vocational Rehabilitation, the Consultant for Sheltered Employment, Mr. Ron Heimerel. Through this Division funds may be available for bringing further focus to community readiness, population numbers, potential for success, and other factors relevant to planning for establishment of a terminal sheltered workshop.

Recommendation 11

The budget available for instructional tools of learning should be greatly increased, and plans should be made to relate in some formal way with one of the Special Educational Instructional Materials Centers in Minnesota, or to begin a satellite program serving the special needs of both the institutional and the local public school special education program.

Related Findings and Rationale:

a) One of the most obvious deficits in the learning programs at these institutions is the lack of suitable instructional materials and equipment - the tools of learning.

b) Since teachers have had the use of few specialized materials and little equipment, many of them are not familiar with the types of special materials available, and need a great deal of in-service training regarding selection, operation, and appropriate application of these materials.

c) The number and kind of quality "tools" on hand is extremely small when compared with the available technology.

d) Many learning programs are forced to obtain used or obsolete books and materials from public schools and other sources.

e) The importance of using a multi-modal or multi-sensory approach to teaching mentally retarded children is clear and has been demonstrated. The institutionalized mentally retarded learn least well from books and other written sources. Also, games and devices that embody too many concepts, or that emphasize rote learning are generally not effective. Although there were some exceptions, most of the instructional materials were of these types.

Implementation:

More funds should be allocated for educational materials and equipment by the institutions. These should be line allocations as this type of expenditure is least attractive to those controlling the various federal funds which are available to institutions.

Planning for a State network of Special Education Instructional Materials Center (SEIMC) is now being conducted by the Special Education Section, the Minnesota Department of Education. A number of Centers are currently under development, and generally will be affiliated with the Regional SEIMC Center in Madison, Wisconsin. Responsible agents in the State Department of Welfare should begin formal articulation with the Special Education Section regarding inclusion of institutional programs in the planning for SEIMC's. This would seem to be an ideal area for mutual effort between the local Public School and the institution.

Recommendation 12

Consideration should be given to designating specific institutions as "special purpose" facilities designed to focus scarce and expensive resources to meet more effectively the learning needs of special groups of the institutionalized mentally retarded.

Related Findings and Rationale:

a) The Department of Welfare may, at some point, have to decide to centralize resources that are in short supply and very expensive within one particular institution or another in order to have one strong program rather than three that do not adequately meet the needs of the residents. For example, trends indicate that there will be fewer and fewer very young children in institutions. It would seem that there are some critical differences between programs designed to serve young children and those designed to serve adults. This is especially true in the learning needs and the affective needs area. Obviously, there are differences also indicated in such areas as housing and nutrition.

b) Programs for young children need to be developed and operated by specialists, those who have had extensive training and experience with programs for children. Would it not be more effective to place all young children in one of the institutions more central to the metropolitan area, possibly Faribault or Cambridge, and to design a specific and comprehensive program just for them? This type of pooling of population would make it possible to have at least one effective program for meeting the learning and affective needs of young children.

c) Another area where pooling of resources might be important is the area of the development of comprehensive vocational evaluation and adjustment services. It does not seem economically feasible to develop these rather complex sets of services in all three institutions with equal attention to the factors 1) of employment of quality, well-trained personnel, 2) of identifying and structuring the necessary space for this purpose, 3) of developing the necessary specialized staff development program necessary to keep staff up to date in this ever-changing field, and 4) supplying the necessary hardware and software for the operation and conduct of these programs, etc.

Implementation:

This is a recommendation for "consideration." Although it is apparent to Study Staff that additional focusing of resources and population seems to be necessary if quality programs of learning are to be operated, there may be other, more critical factors involved in the current pattern of having institutions serve population on a regional basis, with intake coming only from those regions.

We are indicating only that those administratively responsible for decisions regarding overall institutional intake patterns be aware that one way to think about improving programs of learning would be to pool critical resources and population to the most effective advantage of both. Specific implementation, or determination of need for further study and analysis of this issue will, at this point, have to be referred to responsible officials.

D. RECOMMENDATIONS FOR FURTHER STUDY.

Recommendation 1

A thorough study of the Owatonna State School should be made, with the primary purpose of determining (1) its appropriate mission and (2) its role in relationship to other social and educational resources.

Related Findings and Rationale:

a) Given the size of the staff, and the related physical plant and facilities, Owatonna State School is a very expensive facility to maintain, and the per-resident cost is high.

b) The present population of primarily educable retarded Jr. and Sr. High School age residents are there, based on stated selection criteria, because they are both emotionally disturbed and mentally retarded, and are in need of a "treatment" environment.

c) Although many job titles and stated goals are "treatment" related, the general competencies of staff and the day to day management of residents reflect typical residential and educational environments, rather than intensive treatment.

d) Most of the residents observed did not seem to reflect inter-personal and affective needs significantly different from thousands of other children called educable retarded who are able to remain in their communities. Conversations with various state school administrators, a check on population distribution (See Appendix A), sampling of case histories, plus conversations with staff and residents, lead the Study Staff to believe that most Owatonna placements are made for other than treatment reasons, and more likely reflect 1) family problems, and/or 2) lack of local public school special education resources.

e) The type of educational or learning program, the support resources necessary, the degree to which education must be structured as the primary "treatment" modality, and the type of learning program staff necessary are all highly contingent on the predicted needs of the resident population. Study Team observations regarding the needs of the population served were at variance with the stated objectives of the Institution, and with the methods used to meet the habilitation needs of the residents.

The Study Team suggests that most Owatonna residents could possibly be served elsewhere (their own community and school district) with use of sound case management practices, and that an extensive in-patient treatment resource is not necessary.

If the Study Staff is in error in this judgement, and if most of the resident population indeed demonstrates signficant emotional pathology not treatable through community educational and clinical resources, then the character of Owatonna State School must change drastically. If only a core of 40-50 students need intensive treatment on in in-patient basis, and the rest of the residents could be as adequately served at the community level, than the question arises as to the appropriateness of Owatonna in terms of its distance from extensive clinical resources in terms of appropriateness of physical plant, staffing patterns, etc.

f) Of those staff the Study Team spoke with, morale seemed to be somewhat depressed, and there appeared to be a schism regarding attitudes and philosophy between learning programs staff and nursing or "treatment" personnel. The Study Team could hypothosize a number of reasons for this, and primary among them is the probable fact that goals and practices are designed on an artifically drawn conception of what the population's habilitation needs are.

g) The Study Staff feels that much of what has been stated above (a-f) has substance, but must be treated as less than "gospel" at this time. These statements are registered primarily as strong impressions. The efforts of Study Team staff were divided between four State Institutions, and Owatonna State School had to be treated as a separate study within a study because its program and population were so different from the other three. This division of effort, and the need for the overall Study design to assess the learning program in the other three institutions, resulted in an inadequate study base for extensive and conclusive study of Owatonna. Further substantive conclusion can not be adequately made at this time, nor can concrete suggestions for change be put forth without much more formal and comprehensive study.

The Study Staff has developed a large number of recommendations regarding improvement of learning programs in Owatonna, but feel it would be irresponsible to suggest change if these suggested changes are based on assumptions regarding the type of population served. As our specific recommendations are based on a specific perception of the population, and since this perception of the population has not been validated, we are recommending only that this Institution be given benefit of full and comprehensive study, and that a specific study design be developed to consider in detail some of the factors alluded to above. Does Owatonna have a role as a "State School" in today's and tomorrow's world of growing extent and sophistication of community level resources? Why are students sent to Owatonna? Because they need "treatment?" If persons sent to Owatonna are indeed "emotionally disturbed," is Owatonna the most appropriate resource? Could funds expended to support Owatonna eventually be used as case management monies designed to help these retarded children remain in the community? And many other questions that must be answered through some structured means.

Implementation:

The State Department of Welfare and Education should cooperate in initiating a formal, comprehensive study of Owatonna State School.

Funding for such a study is possible through a number of sources, with likely ones being the Title I Amendments which funded this study, a Title VI (P. L. 89-10) State-initiated grant, or Vocational Rehabilitation funding sources.

While a formal proposal outlining the proposed study is not included in this document, the Study Staff will make a basic proposal outline available if State Welfare and Education personnel are interested in pursuing this recommendation in detail.

Recommendation 2

A comprehensive study should be conducted to investigate utilizing various local educational agencies as vehicles for increased, more flexible funding, and for program development and supervision.

Related Findings and Rationale:

a) Existing funding sources for the learning programs and the institutions for the mentally retarded have a rather narrow base of funding. This narrow base has limited not only the expansion of program, but the support of the quality of existing programs.

b) One major way to broaden the funding and program operation base would be through the assignment of responsibility for these institutional learning programs to local public schools, and to the State Department of Education. If the local educational agency were to accept major responsibility for conduct of the programs, both the funding and the philosophical base of the learning programs would certainly be expanded through the use of the special education aids, the foundation aid formula and through the federal funds now available for education.

c) There is now in Minnesota some precedent for public school involvement with educational programs in residential institutions. The Mental Health institutions, Corrections and Court Service institutions, and a number of private non-profit treatment institutions are examples.

d) Public schools now have very minimal involvement in conduct of the learning programs in institutions for the mentally retarded. The State Department of Education also has only very minimal conduct with the learning programs in these institutions. This has been due in part to the long standing tradition of institutions for the mentally retarded being fiscally and administratively a Department of Public Welfare responsibility. There have been few significant attempts to differentiate institutional learning programs from the other medical and custodial aspects of daily living for those who are institutionalized, and to involve the local public school in these programs of learning. The Study Team feels this can be done.

Also, until the past two or three years, the question of residency for handicapped children living away from their homes has been a matter of much confusion. The 1965 legislature, however, clarified many residency problems related to handicapped children.

This legislation, indeed, has helped to pinpoint responsibility for educational responsibility for a large number of handicapped children and young adults. These laws, however, as indicated in earlier recommendations, exclude children residing in state institutions, where the institution conducts its own program of education, from the applicability of local district responsibility. In addition, school districts have generally and traditionally not seen it as their role to provide services for children who were called "trainable." As pointed out in earlier recommendations, the distinction between trainability and educability is essentially a convenient artifact not necessarily related to adaptive ability except at the extremes of the definitions. Although school services for trainable mentally retarded children is still not mandatory upon Minnesota school districts, a large number of Minnesota schools do voluntarily provide services, and are eligible for the special education reimbursements. It seems clear, however, that services will be eventually mandatory upon schools in terms of providing for "trainable" mentally retarded children. If this is not done by the State Legislature, the question may eventually be settled through legal action (related to constitutional or civil rights of an individual) of concerned parents or parent groups. At any rate, public schools are at this time accepting responsibility for a wider range of individual differences within mentally retarded children than they have in the years past.

This would seem to be important in creating a climate for talking with school personnel regarding their possible involvement in the learning programs in institutions for the mentally retarded.

e) As the questions related to legal, procedural, and philosophical aspects and a time-table for public schools to become involved with learning programs in these institutions are so difficult to define and answer, we are recommending either that the current Study be extended, or that a separate follow-up activity be designed with the objective of exploring all matters related to the more detailed legal involvement of the local public schools, and to begin discussing with school personnel their ideas and perspectives with regard to this issue. Incumbent as a part of this follow-up activity would be subsequent actions to propose the necessary legal changes and to work with both the State Department of Welfare and the State Department of Education regarding complications relating to the various regulations and directives now in force for each of the respective Departments. Obviously, there would be many roadblocks to expanding the involvement of the local educational agency in learning programs for the institutionalized mentally retarded, but the Study Team feels that the benefits for long range program development could be so significant that it urges a sincere attempt to at least analyze the nature of the problem in more detail.

Implementation:

The Commissioners of Welfare and Education should initiate a comprehensive activity designed to explore all aspects of the question of role definition for each of their Departments as related to the State institutions for the mentally retarded, and the learning programs therein.

Included in this investigation would be a complete analysis of the feasibility of redesigning the legal and political structure to enable local school districts to be of assistance in providing both a broader funding base and a broader base for supervision and program development than is possible under the current structure.

CHAPTER VII

STUDY SUMMARY

This study of Education Programs in Minnesota's Institutions for the Mentally Retarded was commissioned by the State Department of Public Welfare, and was conducted by the Minnesota State Department of Education, the Minnesota National Laboratory.

The "charge" to Study Staff was essentially to identify learning program needs and to make recommendations regarding quality control and expansion of these programs.

Institutions involved in the Study were the institutions at Faribault, Cambridge, Brainerd and Owatonna. Of these, the first three serve seriously retarded persons of all ages, while Owatonna State School serves the educable mentally retarded to age 21. There are education or learning programs in each of these institutions, with these programs operated by the Department of Public Welfare.

Each of these institutions was visited a number of times by two or more of the Study Staff. In addition, visitations were made to other service facilities for the mentally retarded, and to offices of key personnel in other related public agencies. Data were gathered from institutional sources, from the State Department of Public Welfare, and from other local and State public and private agencies and persons. Formal, detailed questionnaires were completed by staff in each institution; and were used to supply much of the base-rate information found in Appendix A. In addition, each institution submitted various other documents and materials as requested.

On the basis of the information and data gathered from all sources, the Study Staff formed conclusions, and structured recommendations in four major areas:

1. Recommendations germane to the total welfare/institutional system for mentally retarded children and adults.
2. Recommendations germane to the operations of other state and local agencies.
3. Recommendations germane to the on-going conduct of the learning programs in the institution for the mentally retarded.
4. Recommendations for further study.

In the first three of these areas, the Study Staff felt the evidence was sufficient to suggest specific modification in program, or in the philosophical and supportive systems related to the learning programs. The "Recommendations for further study" area deals with the need for more investigation and study of issues which the Study Staff could not explore in adequate fashion within the scope of this Study.

Briefly stated, the major finding was that programs of learning in the State Institutions for the mentally retarded are operating at subsistence levels, both in terms of daily support and in terms of the limited numbers of residents served by these programs. Although many leadership and teaching staff within these programs have attempted to build quality programs, and have in specific instances been somewhat successful, the overall picture reflects a basic inability to provide meaningful learning experiences to most institutional residents.

While the overall current picture is not encouraging, there are a few bright spots visible. Primary among these is the fact that institutional populations are dropping significantly as community resources become more quantitatively and qualitatively adequate. Also important to future program growth is the recent and current interest and involvement of the Federal Government in program funding. "Project Teach," the assignment of Department of Educational Regional Special Education Consultants to the rural areas, and other significant directions and programs are federally funded. Some specific directions within the various institutions are also encouraging. The expanded use of para-professionals, the expansion of programs of learning to the wards and cottages, the significant attempts to eliminate many dehumanizing aspects of institutional life, and the expanded contacts with the community and local schools should be encouraged as important to program quality and growth.

Federal funding and the other "bright spots," however, are not likely to overcome the very visible fact that, with the exception of Owatonna, less than one-fourth of the residents of the institutions are receiving any form of organized learning experience, and those that are are receiving only limited services. Massive and flexible funding from some source will be necessary if current learning programs are to become more effective and if almost every resident is to have access to significant and structured learning experiences.

It is clear that a broader and more flexible funding and philosophical base is needed for significant change to occur. The Study Staff feels that these changes in quantity and quality will not occur without the extensive committment and involvement of the Minnesota State Department of Education and of Minnesota's local school districts. Programs of learning in the institutions, whether for children or adults, should be more closely aligned for administration, supervision, and funding with the local educational agency. As was stated earlier in this report, education and programs of learning are the full-time responsibility of this State's Education System, while it is only one of many "hats" the Department of Public Welfare must wear.

In summary, in spite of the many dedicated efforts made by specific persons and offices, learning programs in Minnesota's Institutions for the Mentally Retarded do not reflect the promise that "education" has for helping the institutionalized mentally retarded improve their personal and economic productivity and well-being. We hope that this Study and subsequent efforts by responsible officials and interested persons will bring that promise into clearer focus for those mentally retarded who are now effectively disenfranchised from the right to improve their status.

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APPENDIX A

Statistical and Data Abstracts

These are selected statistical and data abstracts, rather than a complete compilation of information used in the study. They are intended to give backgrounding to the findings and conclusions of the study.

Table 1

Trends in Total Population of Minnesota Institutions for the Mentally Retarded and Epileptic (Source: DPW Statistical Reports).

Year	Population
1880	21
1890	301
1900	721
1910	1231
1920	1742
1930	2306
1940	3623
1950	4412
1960	6046
1964	6339
1965	6276*
1966	6066*
1967	5912*
1968	5565*

* = decrease from previous year.

Table 2

Mental Levels and Ages of Residents in Minnesota Institutions for the Mentally Retarded (June 30, 1967).

Level	%	Age	%
Severe or profound (IQ under 30)	37%	Under age 5	.1%
Moderate (IQ 30-50)	37%	5 - 19	32%
Mild (IQ 50-70)	15%	20 - 29	23%
Borderline (IQ over 70)	1.8%	30 - 64	43%
Not mentally retarded	1%	Over age 65	2.5%
Unclassified	9%		

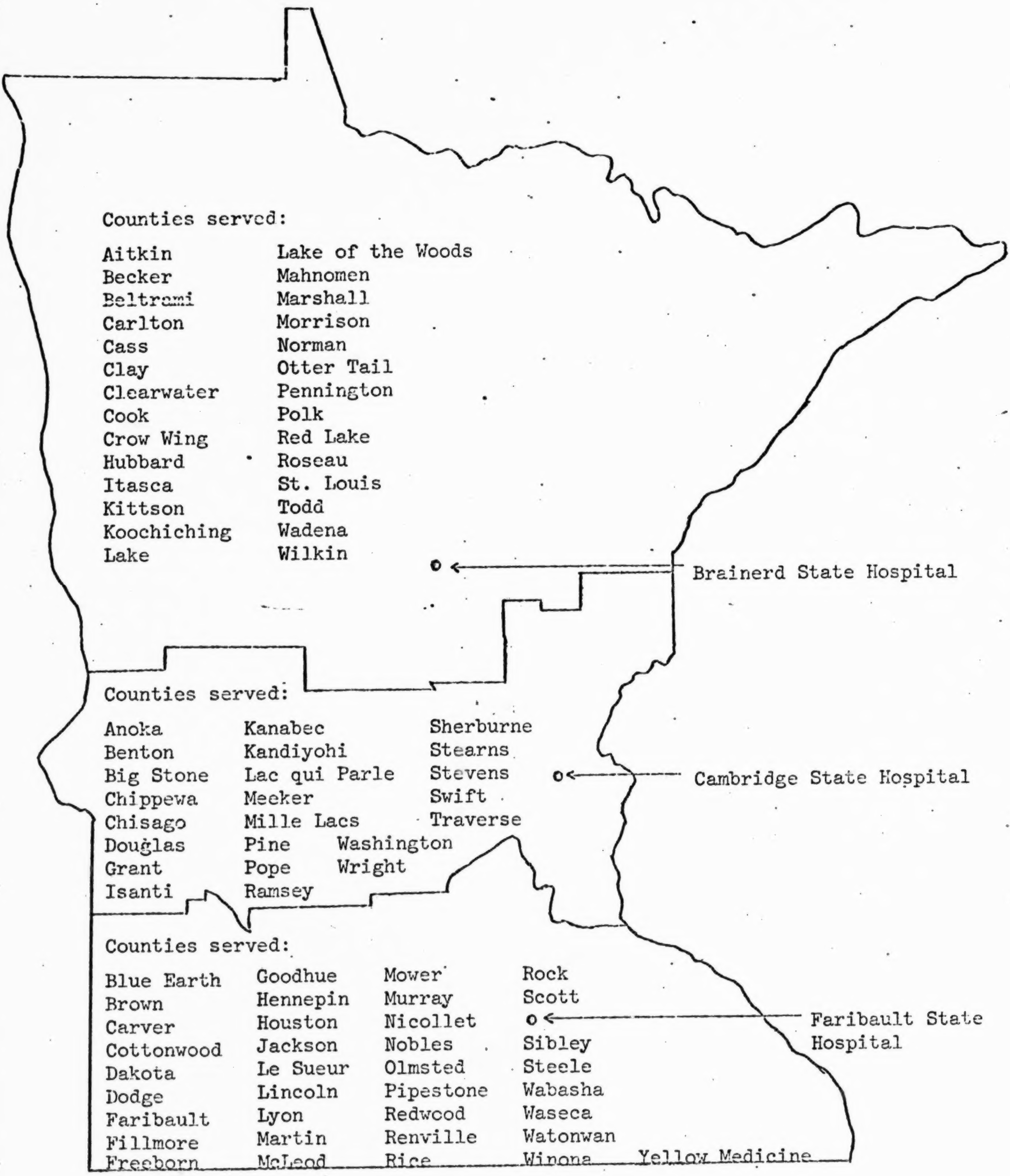
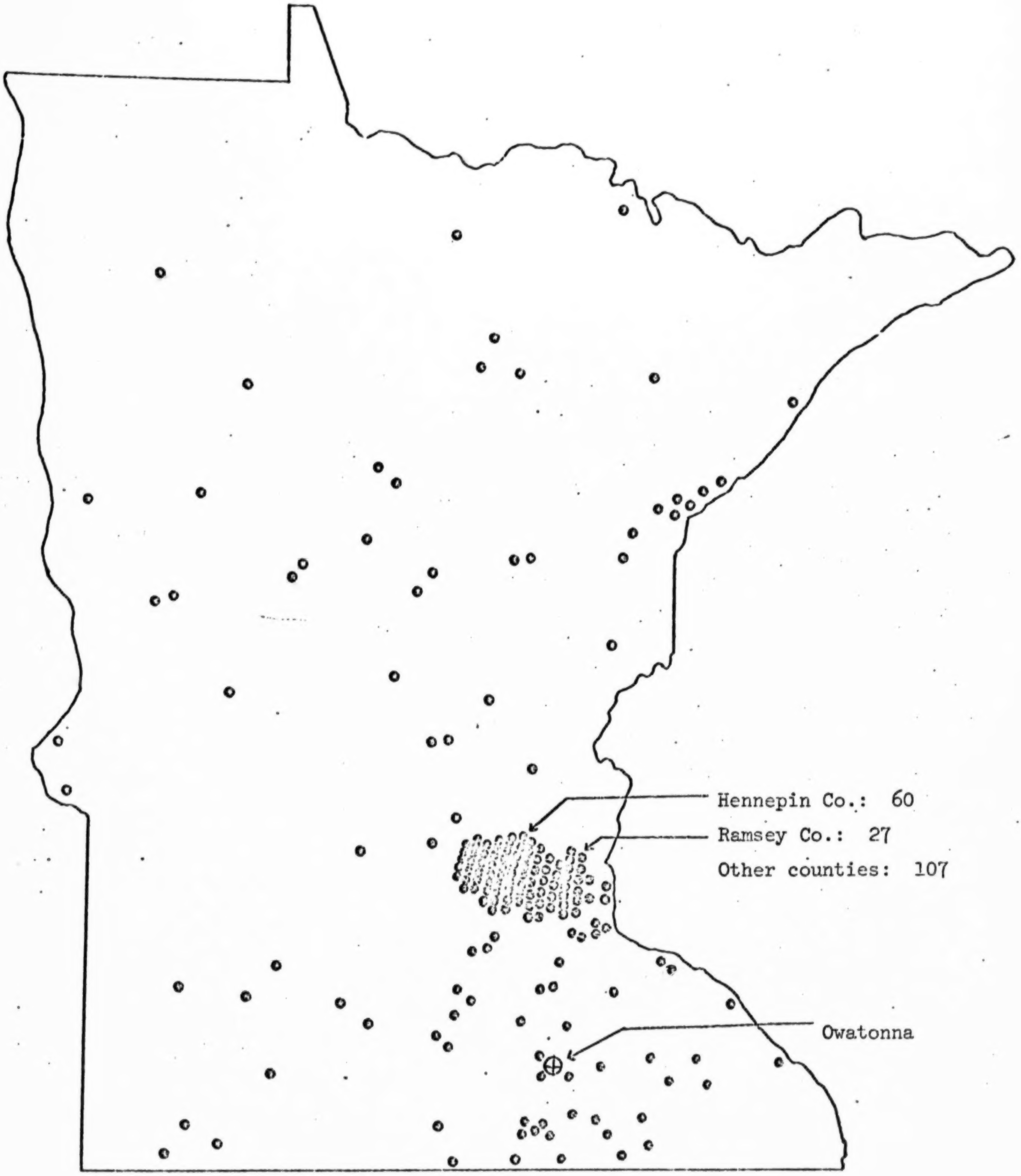

Counties served:
Aitkin
Becker
Beltrami
Carlton
Cass
Clay
Clearwater
Cook
Crow Wing
Hubbard
Itasca
Kittson
Koochiching
Lake
Lake of the Woods
Mahnomen
Marshall
Morrison
Norman
Otter Tail
Pennington
Polk
Red Lake
Roseau
St. Louis
Todd
Wadena
Wilkin
Brainerd State Hospital
Counties served:
Anoka
Benton
Big Stone
Chippewa
Chisago
Douglas
Grant
Isanti
Kanabec
Kandiyohi
Lac qui Parle
Meeker
Mille Lacs
Pine
Pope
Ramsey
Sherburne
Stearns
Stevens
Swift
Traverse
Washington
Wright
Cambridge State Hospital
Counties served:
Blue Earth
Brown
Carver
Cottonwood
Dakota
Dodge
Faribault
Fillmore
Freeborn
Goodhue
Hennepin
Houston
Jackson
Le Sueur
Lincoln
Lyon
Martin
McLeod
Mower
Murray
Nicollet
Nobles
Olmsted
Pipestone
Redwood
Renville
Rice
Rock
Scott
Sibley
Steele
Wabasha
Waseca
Watonwan
Winona
Yellow Medicine
Faribault State Hospital

Figure 1

Minnesota's receiving areas, State hospitals for the mentally retarded.

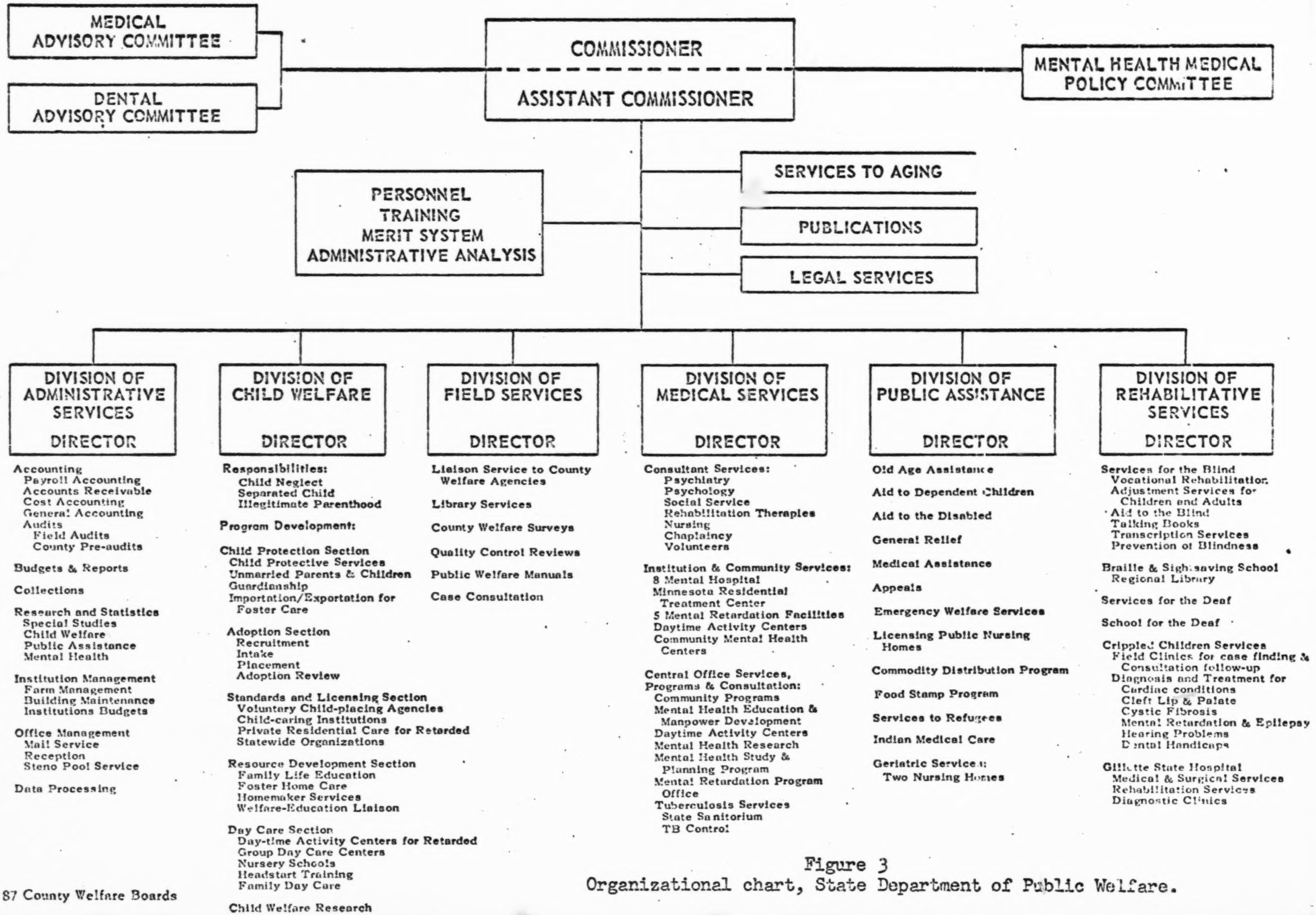


Hennepin Co.: 60
Ramsey Co.: 27
Other counties: 107
Owatonna

Figure 2

Home locations of residents of the
Owatonna State School, Sept. 26, 1968.

Centennial Office Building
St. Paul, Minnesota 55101



DIVISION OF ADMINISTRATIVE SERVICES
DIRECTOR

- Accounting
  - Payroll Accounting
  - Accounts Receivable
  - Cost Accounting
  - General Accounting
  - Audits
    - Field Audits
    - County Pre-audits
- Budgets & Reports
- Collections
- Research and Statistics
  - Special Studies
  - Child Welfare
  - Public Assistance
  - Mental Health
- Institution Management
  - Farm Management
  - Building Maintenance
  - Institutions Budgets
- Office Management
  - Mail Service
  - Reception
  - Steno Pool Service
- Data Processing

DIVISION OF CHILD WELFARE
DIRECTOR

- Responsibilities:
  - Child Neglect
  - Separated Child
  - Illegitimate Parenthood
- Program Development:
- Child Protection Section
  - Child Protective Services
  - Unmarried Parents & Children
  - Guardianship
  - Importation/Exportation for Foster Care
- Adoption Section
  - Recruitment
  - Intake
  - Placement
  - Adoption Review
- Standards and Licensing Section
  - Voluntary Child-placing Agencies
  - Child-caring Institutions
  - Private Residential Care for Retarded
  - Statewide Organizations
- Resource Development Section
  - Family Life Education
  - Foster Home Care
  - Homemaker Services
  - Welfare-Education Liaison
- Day Care Section
  - Day-time Activity Centers for Retarded
  - Group Day Care Centers
  - Nursery Schools
  - Headstart Training
  - Family Day Care
- Child Welfare Research

DIVISION OF FIELD SERVICES
DIRECTOR

- Liaison Service to County Welfare Agencies
- Library Services
- County Welfare Surveys
- Quality Control Reviews
- Public Welfare Manuals
- Case Consultation

DIVISION OF MEDICAL SERVICES
DIRECTOR

- Consultant Services:
  - Psychiatry
  - Psychology
  - Social Service
  - Rehabilitation Therapies
  - Nursing
  - Chaplaincy
  - Volunteers
- Institution & Community Services:
  - 8 Mental Hospital
  - Minnesota Residential Treatment Center
  - 5 Mental Retardation Facilities
  - Daytime Activity Centers
  - Community Mental Health Centers
- Central Office Services, Programs & Consultation:
  - Community Programs
  - Mental Health Education & Manpower Development
  - Daytime Activity Centers
  - Mental Health Research
  - Mental Health Study & Planning Program
  - Mental Retardation Program Office
  - Tuberculosis Services
    - State Sanitorium
    - TB Control

DIVISION OF PUBLIC ASSISTANCE
DIRECTOR

- Old Age Assistance
- Aid to Dependent Children
- Aid to the Disabled
- General Relief
- Medical Assistance
- Appeals
- Emergency Welfare Services
- Licensing Public Nursing Homes
- Commodity Distribution Program
- Food Stamp Program
- Services to Refugees
- Indian Medical Care
- Geriatric Services:
  - Two Nursing Homes

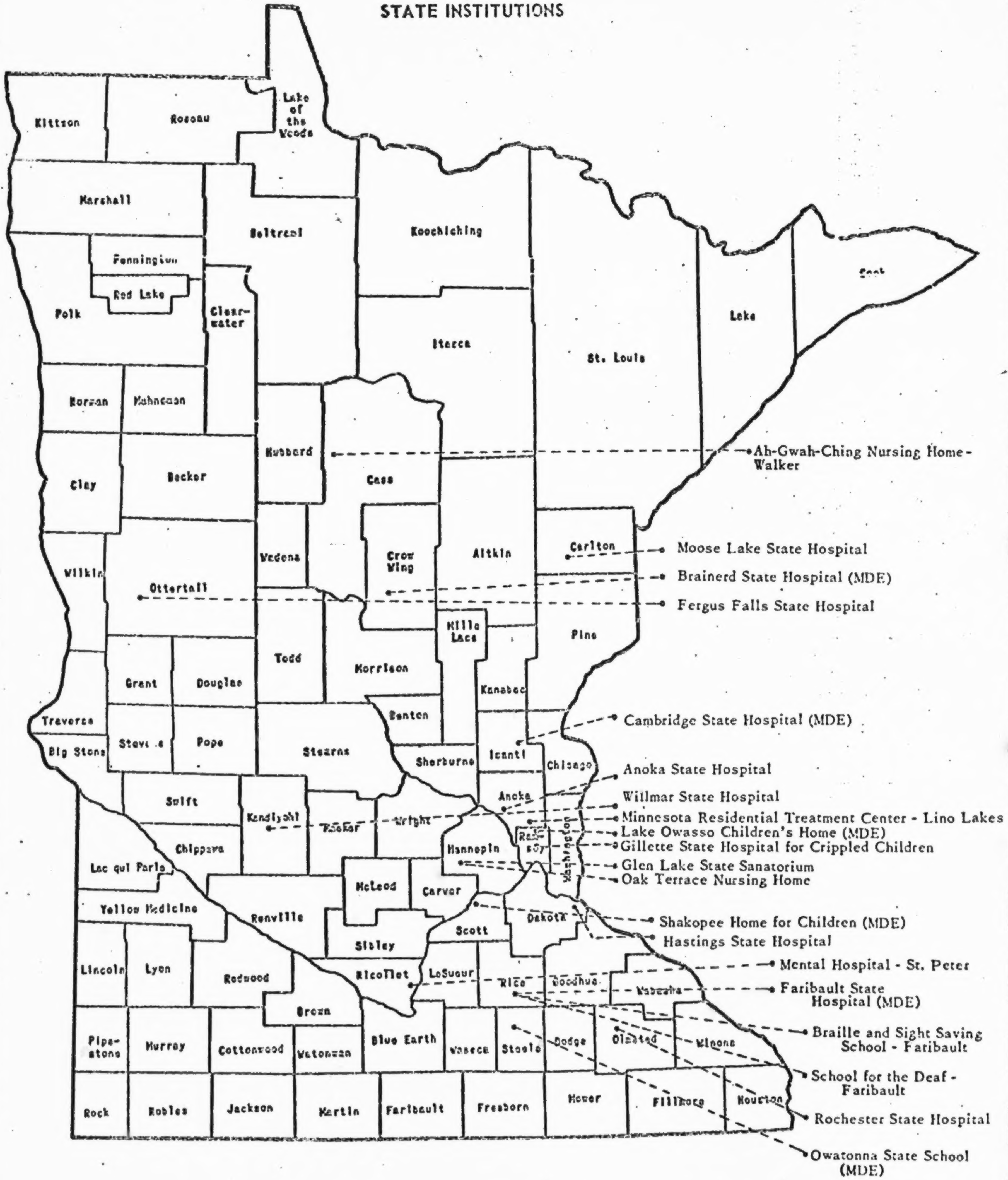
DIVISION OF REHABILITATIVE SERVICES
DIRECTOR

- Services for the Blind
  - Vocational Rehabilitation
  - Adjustment Services for Children and Adults
  - Aid to the Blind
  - Talking Books
  - Transcription Services
  - Prevention of Blindness
- Braille & Sightsaving School
  - Regional Library
- Services for the Deaf
- School for the Deaf
- Crippled Children Services
  - Field Clinics for case finding & Consultation follow-up
  - Diagnosis and Treatment for
    - Cardiac conditions
    - Cleft Lip & Palate
    - Cystic Fibrosis
    - Mental Retardation & Epilepsy
    - Hearing Problems
    - Dental Handicaps
- Gillette State Hospital
  - Medical & Surgical Services
  - Rehabilitation Services
  - Diagnostic Clinics

87 County Welfare Boards

Figure 3
Organizational chart, State Department of Public Welfare.

MINNESOTA'S COUNTY WELFARE BOARDS and STATE INSTITUTIONS


Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching
Pennington
Red Lake
Polk
Clearwater
Cook
Lake
Itasca
St. Louis
Norman
Mahnomen
Hubbard
Clay
Becker
Cass
Wilkin
Wadena
Crow Wing
Aitkin
Carlton
Ottertail
Mille Lacs
Pine
Grant
Douglas
Todd
Morrison
Kanabec
Traverse
Benton
Big Stone
Stevens
Pope
Stearns
Sherburne
Isanti
Chisago
Anoka
Swift
Kandiyohi
Meeker
Wright
Ramsey
Washington
Hennepin
Chippewa
Lac qui Parle
McLeod
Carver
Yellow Medicine
Renville
Dakota
Scott
Sibley
Lincoln
Lyon
Redwood
Nicollet
LeSueur
Rice
Goodhue
Wabasha
Brown
Pipestone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston

Ah-Gwah-Ching Nursing Home - Walker
Moose Lake State Hospital
Brainerd State Hospital (MDE)
Fergus Falls State Hospital
Cambridge State Hospital (MDE)
Anoka State Hospital
Willmar State Hospital
Minnesota Residential Treatment Center - Lino Lakes
Lake Owasso Children's Home (MDE)
Gillette State Hospital for Crippled Children
Glen Lake State Sanatorium
Oak Terrace Nursing Home
Shakopee Home for Children (MDE)
Hastings State Hospital
Mental Hospital - St. Peter
Faribault State Hospital (MDE)
Braille and Sight Saving School - Faribault
School for the Deaf - Faribault
Rochester State Hospital
Owatonna State School (MDE)

Table 3

Personnel of learning programs responsible to Instructional Supervisor (November, 1968).

Position title or function	Brainerd	Cambridge	Faribault	Owatonna
Classroom teachers, EMR	–	1½	1	11
Classroom teachers, TMR	1	1	3	–
Teachers, Ward or Unit	3	–	–	–
Teachers of Deaf or Blind	–	–	1	–
Teachers, Industrial Arts	1	–	–	1
Teachers, Home Economics	1	1	–	1
Teachers, Physical Education	2	–	2	–
Teachers (Therapists), Music	1	–	1	–
Teachers, other (incl. Adult)	2	1	5	1
Speech clinicians	2	–	–	–
Counselors	–	–	–	–
Industrial Therapists	–	–	–	–
Corrective Therapists	–	–	–	–
Librarians	–	1	1	–
Technicians (SRST)	9	–	4	–
Aides	7	–	–	–
Trainees, college student	8	–	–	–
Administrative assistants, prof.	–	–	2	–
	37	5.5	20	14

Table 4

Personnel engaged in learning programs, not responsible to Instructional Supervisor. (Note: All except CVRP personnel are responsible to other sections in Rehabilitation Therapies Department.) November, 1968.

Position title or function	Brainerd	Cambridge	Faribault	Owatonna
Supervisor, Project Teach	–	½	1	–
Supervisor, Child Development	–	–	1	–
Teacher, Special	–	–	1	–
Teachers, Industrial Arts	–	1	–	–
Teachers, Home Economics	–	1	–	–
Teachers, Physical Education	–	–	–	2
Music Therapists	–	–	1	1
Speech Clinicians	–	1½	2	1
Counselors	–	–	1	–
Corrective Therapists	–	1	–	–
Industrial Therapists	1	–	1	–
Industrial Therapy Technicians	1	–	–	–
Technicians, Project Teach	–	–	2	–
Aides, Project Teach, ½ time	–	54	82	–
Program Director, CVRP	1	–	–	1
Counselor, CVRP	3	–	–	1
Social-habilitation Dir., CVRP	1	–	–	–
Teachers, Vocational, CVRP	–	–	–	2
Patient Activity, CVRP	4	–	–	–
Special School Counselors, CVRP	15	–	–	–
	26	59	92	8

Table 5

Q: From what sources were you able to gather (population) statistics?

Brainerd:	Files of Administrator, Medical Records, Psychologist, Social Service, Rehab and Education files.
Cambridge:	Old records.
Faribault:	Addressograph, Social Service Record, Medical Files, Psychology Records, Rehab Records, Chaplaincy Records, Federal-project Records, and various department heads.
Owatonna:	Child Care Office.

Table 6

Q: If estimates of population were reported, whose estimates were used?

Brainerd:	For 1965, all except total population are estimates. Psychologist and Rehab Therapies Director made estimates.
Cambridge:	Blank
Faribault:	Actual figures used.
Owatonna:	Total population figures are correct. Ages are my estimates based on population in each cottage.

Table 7

Q: Describe any difficulties you had in securing the population statistics.

Brainerd:	Very tedious process. Many of the 1965 statistics are estimates. Patient population total for 1965 is not an estimate.
Cambridge:	Accurate records of this type data were not kept years ago.
Faribault:	We had to secure total population of the Hospital, after which we had to insert each resident's CA and IQ (a long laborious task to say the least). Then we had to insert each and every program activity (formal or training or education); from this we were able to compile the necessary facts desired. Needless to say, this took many man hours of the Education, Rehabilitation, Social Service, and Psychology Staff.
Owatonna:	None.

Table 8

Population of Institutions, Elementary Age (6 through 12).

Classification	Brainerd	Cambridge	Faribault	Owatonna
Total residents	144	"These statistics are not available here or at DPW."	232	29 est.
Non-ambulatory	48		59	0
"Profoundly" retarded, need nursing care	65		164	0
(Severely and Moderately retarded omitted from questionnaire; data furnished by Faribault)			62	
Educable (IQ 55+)	0		6	29 est.
In a formal education or training program	40		196	
With vision or hearing loss	14		35	

Table 9

Population of Institutions, Secondary Age (13 through 21).

Classification	Brainerd	Cambridge	Faribault	Owatonna
Total residents	315	"These statistics are not available here or at DPW."	579	150 est.
Non-ambulatory	78		90	0
"Profoundly" retarded, need nursing care	122		348	0
Severely and Moderately retarded (omitted from questionnaire; data furnished by Faribault)			209	
Educable (IQ 55+)	20		22	150 est.
In a formal education or training program, incl. Project Teach	286		483	
With vision or hearing loss	20		60	

Table 10

Proportions of institutions' resident populations reported to be enrolled in any learning program under the supervision of the Instructional Supervisor.

	Brainerd	Cambridge	Faribault	Owatonna
Total resident population	1246	1482	2157	179
Percent enrolled in learning programs, Instruction Sections	21.5%	18.5%	21%	86%

* = population figures approximate, not from fully comparable sources.

Table 11

Residents reported to be enrolled in programs under supervision of the Instructional Supervisor (Project Teach, which is under other supervision, is not tallied here).

Classification	Brainerd	Cambridge	Faribault	Owatonna
Not mentally retarded	3	6	0	0
Educable (IQ 55+)	49	143	120	140
Trainable (IQ 30 to 54)	183	84	329	10
Below trainable	29	0	0	0

Table 12

Residents reported to be enrolled in programs under supervision of the Instructional Supervisro, classified by age (Project Teach is not included here).

Age Classification	Brainerd	Cambridge	Faribault	Owatonna
0 - 5	3	0	0	0
6 - 12	46	43	65	25
13 - 20	125	75	240	125
21 or older	90	115	144	0

Table 13

Percentages of residents in each age range reported to be enrolled in the instructional program of each institution under the direction of the Instructional Supervisor. Project Teach is not included. (The percentages are approximate, since the numbers of residents in each age range which form the bases for the percentages were reconstructed from DPW reports which groups ages differently.)

Age Classification	Brainerd	Cambridge	Faribault	Owatonna
6 - 12	30%	15%	20%	86%
13 - 20	80%	20%	50%	86%
21 or older	10%	11%	6%	-

Table 14

Numbers of residents enrolled in the instructional program of each institution, classified by amount of time scheduled to this activity under the direction of the Instructional Supervisor.

Amount of time in instructional program	Brainerd	Cambridge	Faribault	Owatonna
Full day; 5+ hours	36	6	0	24
Half day	86	51	20	102
Quarter day	120	152	429	12
Less than quarter day	22	24	0	12

Table 15

Q: Consider the kind of person who is admitted to your institution during 1968. How long do you think institutional placement will be required for these people? Estimate Proportions. Numbers in parentheses are percentages of 1966-67 discharges from each of the institutions.

Anticipated length of institutional placement	Brainerd	Cambridge	Faribault	Owatonna
Less than 5 years	65% (38)	40% (33)	35% (11)	90% (51)
5 to 10 years	20 (6)	40 (18)	20 (19)	7 (38)
More than 10 years	15 (56)	20 (49)	45 (70)	3 (11)

Table 16

Q: Compared to this year, do you expect the population of your institution (next year) (five years from now) to increase, remain the same, decrease?

Year forecast	Brainerd	Cambridge	Faribault	Owatonna
Next year, 1969	Decrease by more than 5%	Decrease by more than 5%	Decrease by more than 5%	Remain the same
Five years from now, 1973	Decrease 10-50%	Decrease 10-50%	Decrease 10-50%	Remain w/in 10%

Table 17

Q. What do you expect the age distribution of your institution's population to be five years from now? Figures in parentheses are approximate reconstructions of percentages from 1968 DPW statistical reports.

Age Classification	Brainerd	Cambridge	Faribault	Owatonna
Under age 21	42% (25)	28% (40)	40% (30)	100% (100)
21 to 50	52 (50)	60 (45)	45 (50)	
Over age 50	6 (25)	12 (15)	15 (20)	

Table 18

Q: What are the feasible goals for your population? What percentages of the patients with whom you deal have potential for eventually reaching these levels of competence or satisfaction, assuming that your services are as effective as you know how to make them? (Replies of both respondents in each institution given here, those of the Directors of Rehabilitation Therapies being given in parentheses. Note that Instructional Supervisors have reference to a smaller, and perhaps more able, population.)

	Brainerd	Cambridge	Faribault	Owatonna
LEVEL OF COMMUNITY COMPETENCE				
Full independence	3% (5%)	14% (10%)	5% (5%)	55% (75%)
Semi-independence	82 (50)	60 (80)	25 (30)	35 (25)
Full dependence	15 (45)	26 (10)	70 (65)	10 (0)
PERSONAL SATISFACTION, SELF-FULFILLMENT				
More than average	1% (3%)	3% (0%)	60% (20%)	20% (5%)
Like average person	4 (80)	47 (10)	25 (40)	20 (80)
Less than average	75 (5)	33 (40)	5 (5)	30 (10)
Chronically dissatisf.	15 (7)	8 (30)	5 (5)	20 (5)
Lack capacity for satisfaction	5 (5)	9 (20)	5 (30)	10 (0)
OCCUPATION				
Competitive potential	5% (5%)	29% (10%)	5% (2%)	50% (70%)
Sheltered Employment	75 (35)	36 (80)	15 (3)	20 (20)
Work Activity	10 (20)	19 (8)	25 (20)	15 (8)
Daytime Activity	8 (20)	14 (2)	45 (50)	10 (2)
Lack activity potential	2 (20)	3 (0)	10 (25)	5 (0)
ABOVE BASED UPON WHAT NUMBER OF PATIENTS?	276 (1222)	277 (?)	500 (2157)	150 (187)

Table 19

Q: How is the content of an individual patient's instructional program determined? Please identify the kind of information upon which the determination is based, the staff member(s) who make the determination, whether the determination is made as a group decision or individually, and who, if anyone, carried final decision responsibility.

Brainerd:	The treatment team responsible for the patient's program refers the patient to the Instructional Supervisor for admission to the school program. The referral form (copy enclosed) lists the different educational programs and the team is asked to refer to a specific program. The Instructional Supervisor discusses the referral with one or more teachers to work out the best placement for the patient.
Cambridge:	Eleven factors considered, "age" to "basic needs of individual residents in light of his or her potential."
Faribault:	a. by resident needs b. age, IQ, MA, physical involvements, social level of adaption c. an evaluation to determine present functional level d. individual instructor; general curriculum areas by group discussion
Owatonna:	1. needs of student 2. test results and school records submitted by counties 3. test results administered by O.S.S.

Table 20

Q: How is a decision made that a given patient should participate in the instructional program?

Brainerd:	Patient is referred to Instructional Supervisor by treatment team. Instructional Supervisor asks a teacher to evaluate child and determine whether or not the child could gain from being placed in school. Evaluation sometimes takes several weeks.
Cambridge:	1. staff planning conferences (teachers involved) 2. cottage team meetings (teachers are involved) 3. special referrals
Faribault:	By building team or unit team meetings, the child is reviewed as his potential and needs. If it is felt he can benefit from the type of program we can offer him, he is included. For adults, this is based on proximity to community placement, or developing to his full potential.
Owatonna:	1. recommendations of county 2. recommendations of Program Director 3. recommendations of team 4. student needs

Table 21

Q: What diagnostic procedures are carried out by, or at the case-by-case request of, the Rehabilitation Therapies personnel?

Brainerd:	Speech and Hearing Psychological testing upon the teacher request Achievement test given by teacher TMR Performance Profile for the Severely and Moderately Retarded Primary Progress Assessment Chart for Social Development by H. C. Gunzburg Kennedy Foundation Physical Fitness Test for MR Hayden Fitness Test for MR
Cambridge:	Request Pre-vocational evaluation Request diagnostic procedures funded by DVR Speech and Hearing evaluation OT and/or PT evaluation Jastek Wide Range Achievement
Faribault:	Speech Therapy is engaged in a hospital audiological survey. They also do articulation and language surveys upon request. Occupational Therapy utilized the Frostig Developmental Test of Visual Perception and the Beery Butkanica Test for determining perceptual tests. They also utilized Gesell Developmental Schedules for evaluating physical disabilities. Physical Therapy is involved with evaluative procedures which aid physician in making such diagnosis as: muscle strength, ROM deformities, gait analysis, reaction of degeneration evaluative measures. Industrial Therapy: individual counseling and assignment to training and work for therapeutic purposes.
Owatonna:	Achievement tests Physical fitness tests; unstandardized Vocational Evaluation Teacher-made tests in all areas Speech and Hearing

Table 22a

Q: What patient records, other than those generated within the instructional program, are regularly or routinely viewed by the instructional staff?

Brainerd:	Medical records are always available to the instructional staff and are routinely checked for pertinent information. Ward charts are also available, and progress reports of all Rehabilitation Therapies personnel.
Cambridge:	Main medical record file; progress notes of 1. doctors evaluation and routine and special prescriptions 2. consultants (psychiatrist, physiatrist, occulist, etc.) 3. all rehabilitation therapies 4. nursing daily and weekly notes
Faribault:	Resident's personal file and individual chart within the living area (Ward chart).
Owatonna:	All files.

Table 22b

Q: What reports of patient status or progress are routinely made by the staff of the instructional program to persons outside the instructional program?

Brainerd:	Three-month progress reports to medical record, rehabilitation therapy department, and teachers. Oral reports at staff meetings and team meetings.
Cambridge:	Progress notes, anecdotal record, pre-vocational rating, and achievement tests. Oral reports at team meetings.
Faribault:	Quarterly progress report, others when there is a change of program. Oral reports at team meetings. Daily medical chart is maintained.
Owatonna:	Yearly to social service, on request to social service or program directors, oral reports at team meetings.

Table 23

Q: What consulting services have you received from the State Department of Education and Welfare within the past two years? Consider only consultation in specific regard to the instructional program. What consultation have you received from consultants engaged for that purpose from outside state government?

Brainerd:	Education: None	Welfare: None	Other: None
Cambridge:	I visited (consultant) and invited her to visit us. (Consultant on PL 89-313) has made periodic visits.	Welfare: None	Other: Visits for other reasons
Faribault:	Education: None	Welfare: None	Other: None
Owatonna:	Education: None	Welfare: None	Other: None

Table 24a

Q: What in-service training programs, specific to the personnel of the instructional section, were carried out last fiscal year?

Brainerd:	Lecture on sexuality of MR, lectures by Psychologist on mental retardation, behavior modification workshop.
Cambridge:	Unit on communications.
Faribault:	Meetings with psychologist regarding tests, meetings to decide type of progress reports, curriculum development, meetings on audio-visual.
Owatonna:	Two-week program dealing with emotionally disturbed children last spring. This involved all personnel. Money for this project was obtained through PL 89-10 funds. The program was very successful and responsible for our present reorganizational project.

Table 24b

Q: What are your in-service training plans for this year?

Brainerd:	Weekly staffings, monthly rehab therapies meetings, hospital-wide inservice committee, workshop conducted by mental health specialist (to be funded under Title I, PL 89-10), workshop on language development.
Cambridge:	Field trips to Chippewa Falls, St. Paul Schools, and Faribault. Units on perceptual impairment, behavior modification, and human motivation.
Faribault:	Continuation of last year. Use of regional special educational consultant and (new) program coordinator. Weekly meetings.
Owatonna:	No specific plans at this present time.

Table 24c

Q: What has been the participation in professional meetings and conferences by staff in the instructional program during the past two years?

Brainerd:	MEA, several institutes and conferences by individuals, Rehabilitation Therapies Conference.
Cambridge:	Institutional rehabilitation conference, ARC, MEA, CEC, CMEA, AAMD, etc. on individual basis.
Faribault:	All staff attended institutional rehabilitation conference in Rochester. SEMA, MEA, individual.
Owatonna:	Our professional staff may attend any or all meetings or conferences of any professional organization of which they are members at their own expense. This would include AAMD, MEA, SEMA, CEC, etc. Four teachers attended Omaha AAMD meeting.

Table 24d

Q: What site visits to other program have been made by instructional staff during the past two years?

Brainerd:	Several Minnesota facilities visited by most education staff. Also southern and northern colonies in Wisconsin.
Cambridge:	Hammer, Fraser, Christ Child Schools, Chippewa Falls Colony, Wisconsin, Fergus Falls State Hospital, and Brainerd CVRP.
Faribault:	Outreach, CSRC, Cambridge State Hospital, St. Coletta's in Wisconsin, Brainerd and St. Peter Hospitals, Crowley School, St. Paul, TMR Faribault, TMR Northfield, Gillette State Hospital. (Teachers have two visitation days per year and bring back reports.)
Owatonna:	Other institutions.

Table 25

Q: Give enrollment of instructional staff in college course for credit in subject related to their work. (School year 1967-68 and summer 1968.)

Brainerd:	Instructional Supervisor, music teacher, adult practical education teacher, and physical education teacher; total 36 credits.
Cambridge:	Director rehabilitation therapies; total 19 credits.
Faribault:	Ten teachers, 3 SRST; total of RST; total of 71 credits.
Owatonna:	One teacher earned MA in Voc. Rehab Counseling, 8 teachers and administrators attending school at present.

Table 26

Q: Please describe what your particular institution and department needs in order to conduct an educational program as well as you know how.

Brainerd:	Personnel space and equipment. Would like to see more flexibility in the education budget so that equipment or supplies could be purchased sooner. Miscellaneous funds for student field trips are too difficult to obtain. School could use a vehicle for field trips. Need audio-visual and life skill training equipment for non-project use. Need incentives for staff self improvement, especially some time without loss of pay. Salary adjustment for college credit.
Cambridge:	Personnel, equipment, and building. Cambridge and DPW have to see education as a more vital part of the on-going therapy program so sufficient budget can be made available. Need in-service training budget and petty-cash fund. Need full-time school program, grades 1-12. Should change label from retardation to learning handicapped. Need formulation of goals for education. Need tax support and educational supervisor. Need incentive for staff self improvement.
Faribault:	Specific personnel, equipment, and furniture. Sheltered workshop equipment. Activity rooms. More adequate and more flexible budget for instructional equipment and supplies. Close relationship with local and with state educational agencies. Funds for expansion and enrichment of educationally oriented programs going into the community. Funds for upgrading professional staff: stipends, travel allowances, special funding for the blind, deaf, and physically handicapped.
Owatonna:	Better diagnostic methods, remedial instruction, flexible classrooms, curriculum development. Need teachers oriented to learning disabilities. Need help from outside consultants. Should have better coordination with all areas of institution. Personnel equipment, especially audio-visual. Organizational stability. Better information on school budget, what other monies are available to us, and how we go about using them.

APPENDIX B

PATIENT CENSUS PROGRAM

FARIBAULT STATE HOSPITAL

PATIENT CENSUS PROGRAM, FARIBAULT STATE HOSPITAL

The Faribault State Hospital has developed an ingenious information tool, using Addressograph equipment. This was developed because, as the hospital psychologist reports, "Every institution must know for its own use, and often is expected to provide to others, detailed information about its residents. Such information is frequently compiled independently by various staff members, laboriously from medical or ward records or from verbal reports, and is time consuming, subject to errors, and quickly outdated. We saw a need for a system of collecting, storing, and retrieving important information about residents. We call the resulting H.I.P. Project the Patient Census Program."

Uses of Patient Census Data

The data are used for long-range planning, administration of programs, and research.

The psychiatric unit, training for the blind, speech therapy, vocational rehabilitation, education, community placement, etc. use the information to project long-range plans regarding buildings and staffing needs, and in order to give the basis of legislative requests.

In the administration of programs, the data are used for identifying and following patients in various services. The medical clinical section uses it for selection and follow-up on Mantoux, x-ray, orthopedic, and other services. Selection for distinctive educational programs or vocational rehabilitation, as well as for identifying religious education and chaplaincy needs, are another administrative function of the data system.

In research, the data have been used for the correlation of medical, psychological, and social phenomena. For example, the relationship between hereditary forms of retardation and behavioral functions or abnormality, or the relation between social and birth history data, have been investigated. Selection of subjects for research purposes is also facilitated.

Teaching and training of personnel or students is served by locating residents with certain demonstrable conditions, backgrounds, or behavior.

Data Collected

The amount of changeable data was restricted by concentrating upon fixed data (birth date, history prior to admission) where feasible. Some data such as participation in particular programs is registered in the information system after the participation has been completed.

The data gathered do not normally include further information gathering, such as contacting families. It is gathered from patient records, and trained clerical and technician personnel are used for most data identification and recording. Two specially trained interviewers and observers with college training interview staff and observe patients directly for behavioral data. The departments of the institution submit their information, and basic diagnostic information is reviewed.

The kinds of data recorded include the usual personal and identifying information. The family history data, the birth history of the patient, and his social history are compiled. The psychiatric, medical, and psychological diagnosis, together with the somatic disorder history, are recorded.

A major class of information recorded on each patient has to do with behavior development and adjustment. Sensory competence, motor activity, coordination, diet and eating, and a wide range of social and personal development and skills are included. Ability to perform tasks and social behavior problems are recorded.

Surgical, laboratory, and dental procedures are recorded as is the institution work and other program histories. Current program information and separation information are recorded by tabs rather than by permanent card punches.

Data Storage and Retrieval

An Addressograph-Multograph 2035 system is used for storage and retrieval of information. For each patient, 8 two-part plates are completed. The plate has an embossed metal section which gives identifying information, and a card-board section in which information can be coded by punched holes. The metal section is printed by the standard machine for making Addressograph plates. The holes are punched in a small machine with a key board giving access to 23 columns of 5 holes each on each of the cards. The plates are sorted and read by an additional Addressograph machine which both prints out lists and counts categories. The printer can provide basic lists of residents and can count 18 categories or category combinations. It can locate individuals with the characteristics for which it is programmed. For example, it can locate all cases able to walk without support.

The Addressograph provides a direct print-out struck from the metal plates. It can handle 6,000 plates per hour, and there is no need to otherwise separate or collate the plates. By adding plates, the system has almost infinite expansion possibility. The programming selector is relatively simple to operate.

Uses of Census Program to Date

As of January 1969 all data had been completed and stored on 400 residents. For an additional 2,000 residents, information has been stored on identifying information, somatic disorder history, and behavioral development and adjustment. For 200 more patients, the data on family history, birth history, social history, and diagnosis had been entered.

The information system has been used for striking out lists of patients for medications, diets, clothing, etc. It has been used addressing and mailing. Patients have been located for occupational therapy service and for transfer selection. Research subjects for experimental and control groups have been identified. Residents have been grouped for building placement. Various statistical reports have been compiled from the data bank.

The institution has found that this somewhat automated system frees their personnel from a great deal of tedious, duplicative effort. It produces information quickly and accurately, and the system permits the correcting of errors when they are found.

Problems Encountered

Recruiting professional staff with the special talents to operate this system can be a problem. In addition to this, the system requires substantial work in tooling up. The classifications have to be designed, equipment selected and purchased, forms and manuals produced. Beyond this, time is required to complete data collections. This must be done while continuing regular duties.

Some of the information was recorded ahead of the planned schedule in order to respond to the questions raised by the present study of Educational Programs in State Institutions for the Retarded. When Faribault was asked for information regarding the educational programs of patients, it was able to produce this information rapidly and accurately but only by accelerating its schedule of tooling up. New categories of information were realized to be necessary, and the data had to be entered.

(The Study Team is indebted to the Faribault staff, particularly to Mr. Arnold Madow, for the information regarding the patient census program.)

APPENDIX C

TREATMENT TEAM RESPONSIBILITIES AND MEMBERSHIP

BRAINERD

TREATMENT TEAM RESPONSIBILITIES AND MEMBERSHIP

BRAINERD

RESPONSIBILITIES

1. Evaluating the needs of residents and develop programs to meet those needs.
2. Develop and make recommendations for an overall program structure for the unit and to create a therapeutic atmosphere.
3. Refer patients for appropriate services such as work training, learning activities, recreation, and other special services.
4. Relocation of patients within the program unit.
5. Vacations, ground privileges, downtown privileges.
6. Limit setting. Team may restrict the resident when appropriate to the building for up to one week.
7. The team should be aware of all use of restraint and seclusion and should plan appropriate programs to help the patient without the use of restraint or seclusion.
8. Any questions that arise at team meetings relative to medications, treatments, eye examinations, hearing problems or other medical questions should be referred to the physician caring for these patients, or reviewed when a physician is present at the team meeting.

MEMBERSHIP

Membership of the unit team shall be appropriate ward staff, Unit Director, representatives from the service departments who are working in the unit, i.e., Social Worker, Psychologist, Rehabilitation Department and others as needed by the program unit. At least once a month, a physician should be in attendance at the team meeting.

APPENDIX D

COOPERATIVE VOCATIONAL REHABILITATION PROGRAMS

BRAINERD AND FARIBAULT

COOPERATIVE VOCATIONAL REHABILITATION PROGRAMS

The Cooperative Vocational Rehabilitation Program (CVRP) is the product of an agreement between the State Division of Vocational Rehabilitation in the Department of Education and another state agency such as an institution for the mentally retarded. At the time of this writing, there are CVRP's in the Owatonna State School and the Brainerd State Hospital.

Description and Purpose

Cooperative Vocational Rehabilitation Programs have been developed between the Division of Vocational Rehabilitation (DVR) and other state agencies in order to provide vocational rehabilitation services to groups of people who need these services but who have not been served adequately in the past.

DVR considers its goal to include provision of service to everyone in Minnesota who needs it and is eligible for service. State institutions consider vocational rehabilitation services to be an effective part of their treatment program. The CVRP agreements help both agencies to come closer to their joint goals.

Programming

Each CVRP is programmed to meet the needs of the people it serves. Some programs, such as the one at Brainerd, provide extensive work laboratory experiences to the clients. Others, such as the CVRP at Owatonna, are programmed to take greater advantage of on-the-job work experiences in the community. The balance between these two approaches is struck on the basis of the needs and opportunities of the particular institution.

The technologies of the CVRP's include those of counseling agencies, rehabilitation centers, and work experience units. Assessment of employability, development of vocational diagnosis, and provision of occupational training and preparation are the primary purposes of the programs.

A CVRP permits the extenstion of vocational rehabilitation services into the institution itself, in that clients may be entered into service a considerable time before they are scheduled for discharge. There are no formal limits other than practicality to the time at which service may be introduced in the given case. However, the client must be of employable age when services are scheduled for conclusion. At the other end of the time scale, the CVRP facilitates movement into the working world. The responsibility of DVR can be extended beyond the time of discharge until the client is established in employment, through transfer to the local DVR office.

APPENDIX E

MINNESOTA'S LAWS RELATING TO SPECIAL EDUCATION

Section 120.17 (con't)
Subdivision 2. (con't)

(f) Instruction and services in a state residential school or a school department of a state institution approved by the commissioner; or by any other method approved by him;

(g) Instruction and services in other states.

Subdivision 3. Rules of state board. The state board shall promulgate rules relative to qualifications of essential personnel, courses of study, methods of instruction, pupil eligibility, size of classes, rooms, equipment, supervision, parent consultation and any other rules and standards it deems necessary, for instruction of handicapped children.

Subdivision 4. Special instructions for nonresident children. The parent or guardian of a handicapped child who resides in a district which does not provide special instruction and services within its district may make application to the commissioner for special instruction and services for his child under one of the methods provided.

If the commissioner finds that the local district is not providing such instruction and services, he shall arrange for the special instruction and services provided. If the instruction and services are provided outside the district of residence, transportation or board and lodging, and any tuition to be paid, shall be paid by the district of residence. The tuition rate to be charged for any handicapped child shall be the actual cost of providing special instruction and services to the child including a proportionate amount for capital outlay and debt service minus the amount of special aid for handicapped children received on behalf of that child. If the boards involved do not agree upon the tuition rate, either board may apply to the commissioner to fix the rate. The commissioner shall then set a date for a hearing, giving each board at least ten days' notice, and after the hearing the commissioner shall make his order fixing the tuition rate, which rate shall then be binding on both school districts.

For the purposes herein, any school district or unorganized territory or combinations thereof may enter into an agreement, upon such terms and conditions as may be mutually agreed upon, to provide special instruction and services for handicapped children. In that event, one of the participating units may employ and contract with necessary qualified personnel to offer services in the several districts or territories, and each participating unit shall reimburse the employing unit a proportionate amount of the actual cost of providing the special instruction and services, less the amount of state reimbursement, which shall be claimed in full by the employing district.

Subdivision 5. Nothing in this chapter shall be construed as preventing parents of the handicapped educable child from sending such child to the school of their choice, if they so elect, subject to admission standards and policies to be adopted pursuant to the provisions of Minnesota statutes 1957, chapter 248, and all other provisions of chapter 71, extra session laws 1959.

Section 120.17 (con't)
Subdivision 7. (con't)

(c) When it is determined that such child can benefit from public school enrollment, provision for such instruction shall be made in the following manner:

1. Determination of eligibility for special instruction and services shall be made by the commissioner of education and the commissioner of the department responsible for the institution;
2. The school district where the institution is located shall provide an appropriate educational program for the child and shall make a tuition charge to the child's district of residence for the actual cost of providing the program;
3. The district of the child's residence shall pay the tuition and other program costs and may claim foundation aid for the child.

Subdivision 8. Residence of child whose parental rights have been terminated. The legal residence of a handicapped child for whom parental rights have been terminated by court order and who has been placed in a foster facility shall be the school district in which he has been placed. The school board of the district of residence shall provide the same educational program for such child as it provides for all resident handicapped children in the district.

Section 124.32 HANDICAPPED CHILDREN
Subdivision 1. The state shall pay to any district and unorganized territory; (a) for the employment in its educational program for handicapped children, two-thirds of the salary of essential professional personnel, but this amount shall not exceed $4400 for the normal school year for each full-time person employed, or a pro-tata amount for a part-time person or a person employed for a limited time, including but not limited to summer school; (b) for the employment of an individual jointly with another district or districts or unorganized territory in its educational program for handicapped children, two-thirds of the salary of essential professional personnel, but this amount shall not exceed $4400 per annum for each full-time person employed, for a limited time including but not limited to summer school.

Subdivision 2. The state shall reimburse each district or unorganized territory for supplies and equipment purchased or rented for use in the instruction of handicapped children in the amount of one-half of the sum actually expended by the district or unorganized territory but not to exceed $50 in any one school year for each handicapped child receiving instruction.

Section 121.34 MINNESOTA ADVISORY BOARD ON HANDICAPPED, GIFTED, AND EXCEPTIONAL CHILDREN

The "Minnesota Advisory Board on Handicapped, Gifted, and Exceptional Children" is hereby created, consisting of 12 members to be appointed by the governor, one member from each of the nine congressional districts and three members at large. The board shall act only in an advisory capacity to the state board, the commissioner of public welfare, and the state board of health. Four members shall be appointed for one year, four members for two years and four members for three years. Thereafter four members shall be appointed each year, each for a three year term. In making appointments the governor shall give consideration to statewide representation. The board shall elect a chairman, vice chairman and secretary, each to serve for one year. The board shall hold at least four meetings annually. The first meeting shall be called by the governor within 60 days after the appointment of the board. The board shall aid in formulating policies and encouraging programs for exceptional schildren. It shall continuously study the needs of exceptional children. Members of the board shall serve without compensation but may be reimbursed for actual expenses incurred in the performance of their duties by the department from an appropriation made to the department for this purpose.

Section 124.32 (con't)

Subdivision 3. When a handicapped or a mentally retarded pupil cannot be transported on a regular school bus, the state shall reimburse each district or unorganized territory for the transportation or board and lodging of a mentally retarded or otherwise handicapped pupil when approved by the state board, at rates to be determined by the state board, but this amount shall not exceed $225 annually for each such pupil. Transportation funds may be used to reimburse for expenditures in conveying mentally retarded or otherwise handicapped pupils between home and school and within the school plant.

When it is necessary to provide board and lodging for a non-resident handicapped pupil in a district maintaining special classes, reimbursement may be made for the actual cost of board and lodging but not to exceed $900 per annum. This amount may be in addition to the reimbursement for transportation for such child from the place where the pupil is boarded to the school building.

Subdivision 4. The aids provided for handicapped children shall be paid to the district providing the special instruction and services. Foundation aid shall be paid to the district or unorganized territory of the pupils' residence. The amount of aid for special instruction and services for handicapped children may not exceed the amount expended for such special instruction and services for handicapped children for the year for which the aid is paid.

Section 120.04 TRAINABLE CHILD, DEFINED

Every child who is handicapped to such degree that he is not educable as determined by the standards of the state board but who can reasonable be expected to profit in a social, emotional or physical way from a program of teaching and training is a trainable child.

Section 120.18 TRAINABLE CHILDREN

Subdivision 1. Special instruction for trainable children of school age. Every school district and unorganized territory may provide special instruction for trainable children of school age who are residents of such district or unorganized territory.

Subdivision 2. Methods of special instruction. Special instruction and services for trainable children may be provided by one or more of the following methods:

(a) The establishment and maintenance of special classes;

(b) Instruction and services in other districts;

(c) Instruction and services in a state college laboratory school or a University of Minnesota laboratory school;

(d) Instruction and services in a state residential school or a school department of a state institution approved by the state department of education;

(e) By a program of homebound training, teaching and services; or by any other method approved by the state board of education.

Subdivision 6. Placement in another district, responsibility. The responsibility for special instruction and services for a handicapped child temporarily placed in another district for care and treatment shall be determined in the following manner:

(a) The school district of residence of such a child shall be the district in which his parent resides, if living, or his guardian if neither parent is living within the state.

(b) The district providing the instruction shall maintain an appropriate educational program for such a child and shall bill the district of the child's residence for the actual cost of providing the program, as outlined in subdivision 4 of this section, except that the board, lodging and treatment costs incurred in behalf of a handicapped child placed outside of the school district of his residence by the commissioner of public welfare or the commissioner of corrections or their agents, for reasons other than for making provision for his special educational needs shall not become the responsibility of either the district providing the instruction or the district of the child's residence.

(c) The district of residence shall pay tuition and other program costs to the district providing the instruction and the district of residence may claim foundation aid for the child as provided by law. Special transportation costs shall be paid by the district of the child's residence and the state shall reimburse for such costs within the limits set forth in Minnesota Statutes 1961, Section 124.32, Subdivision 3, and acts amendatory thereof.

Subdivision 7. Placement in state institution; responsibility. Responsibility for special instruction and services for a handicapped child placed in a state institution on a temporary basis shall be determined in the following manner:

(a) The legal residence of such child shall be the school district in which his parent resides, if living or his guardian if neither parent is living within the state;

(b) When the educational needs of such child can be met through the institutional program, the costs for such instruction shall be paid by the department to which the institution is assigned;

State of Minnesota
Department of Education
Special Education Section

MINNESOTA LAWS RELATING TO SPECIAL EDUCATION

Section 120.03 HANDICAPPED CHILDREN DEFINED

Subdivision 1. Every child who is deaf, hard of hearing, blind, partially seeing, crippled or who has defective speech or who is otherwise physically impaired in body or limb so that he needs special instruction and services, but who is educable as determined by the standards of the state board is a handicapped child.

Subdivision 2. Every child who is mentally retarded in such degree that he needs special instruction and services, but who is educable as determined by the standards of the state board is a handicapped child.

Subdivision 3. Every child who by reason of an emotional disturbance or a special behavior problem needs special instruction and services, but who is educable, as determined by the standards of the state board is a handicapped child.

Section 120.17 HANDICAPPED CHILDREN

Subdivision 1. Special instruction for handicapped children of school age. Every district and unorganized territory shall provide special instruction and services for handicapped children of school age who are residents of the district. School age means the ages of four years to 21 years for children who are deaf, blind, crippled or have speech defects; and five years to 21 years for mentally retarded children; and shall not extend beyond secondary school or its equivalent.

Every district and unorganized territory may provide special instruction and services for handicapped children who have not attained school age.

Subdivision 2. Method of special instruction. Special instruction and services for handicapped children may be provided by one or more of the following methods:

(a) Special instruction and services in connection with attending regular elementary and secondary school classes;

(b) The establishment of special classes;

(c) Instruction and services at the home or bedside of the child;

(d) Instruction and services in other districts;

(e) Instruction and services in a state college laboratory school or a University of Minnesota laboratory school;

Persons Served

DVR expects that CVRP's will increase the service capability of the agency by approximately 1/3. Eventually, the yearly number of rehabilitants is expected to also increase by 1/3 as the result of CVRP activities. In this connection, it should be noted that CVRP's are operated in 7 state hospitals for the emotionally disturbed and in 2 correctional facilities as well as in 3 of the state institutions for the mentally retarded.

All clients of the CVRP must be eligible or potentially eligible for service from DVR. This eligibility can be interpreted liberally. DVR is empowered to provide diagnostic services in order to determine the potential of a client. Consequently, the selection of clients for service in the CVRP is largely descretionary to the 2 agencies involved.

Since the CVRP's are in their developmental stage, their capacity is not fixed. Something can be inferred regarding capacity from the personnel complement of each CVRP. The CVRP at Owatonna consists of 8: a Program Director, 3 Vocational Teachers, 2 Patient Activity Leaders, a Rehabilitation Counselor, and a Clerk-Steno.

The Brainerd CVRP is somewhat larger. It has a Counseling Supervisor, who is the direct administrative link to the regional DVR Office. There is also a Social Habilitation Director, 3 Rehabilitation Counselors, a Work Skills Training Supervisor, and 4 Patient Activities Assistants. Incumbents of this last type of position are specialized in basic skills and in vocational evaluation. A special teacher in physical education is assigned to the Project as are 2 part-time Industrial Therapists. The Brainerd CVRP also operates through 15 "Special School Counselors." These Counselors were formerely known as Psychiatric Technicians or Psychiatric Aides in the old hospital nomenclature.

Funding and Administration

In each CVRP the cooperating agency (the state hospital) pays 25% of the cost of establishing and operating the program. Most of the cooperating agency share is met through a salary contribution for staff assigned to the program. The money which is actually expended in this way is used to match previously unmatched federal funds for DVR purposes. This meets the balance of the cost of the program.

All of the CVRP staff is supervised by the line administrators of DVR. Both agencies have staff assigned to the program. Some of the staff is engaged without previous commitment to either agency. Other staff members are recruited from within each agency.

Section 120.18 (con't)

Subdivision 3. State board to promulgate rules. The state board shall promulgate rules relative to qualifications of essential personnel, methods of training, pupil eligibility, size of classes, room, equipment, supervision, and any other rules and standards it deems necessary for education of trainable children.

Subdivision 4. Agreements to provide special instruction. Any district or unorganized territory may enter into an agreement to provide special instruction and services on such terms as may be agreed upon, but in that event each participating unit must agree on the method of reimbursement or on some other method approved by the state department.

Section 124.33 TRAINABLE CHILDREN: PAYMENTS BY STATE
Subdivision 1. Amount. The state shall pay to any district and unorganized territory; (a) for the employment in its program for trainable children, two-thirds of the salary of essential personnel, but this amount shall not exceed $4000 per annum for each full-time person employed, or a pro-rata amount for a part-time person or a person employed for a limited time, including but not limited to summer school; (b) for the employment of an individual jointly with another district or districts or unorganized territory in its program for trainable children, two-thirds of the salary of essential personnel, but this amount shall not exceed $4000 per annum for each full-time person employed, or a pro-rata amount for a part-time person or a person employed for a limited time including but not limited to summer school.

Subdivision 2. Reimbursement by state to district for supplies and equipment. The state shall reimburse each district or unorganized territory for supplies and equipment purchased or rented for use in the instruction of trainable children in the amount of one-half the sum actually expended by the district or unorganized territory but not to exceed $50 in any one school year for each trainable child receiving instruction.

Subdivision 3. State to reimburse district for transportation or board and lodging. The state shall reimburse each district or unorganized territory for the transportation or board and lodging of trainable children when approved by the state board but this amount shall not exceed $225 annually for each such child. Transportation funds may be used for conveying trainable children between home and school and within the school plant.

Subdivision 4. Aids are additional to basic and equalization aids. The aids provided for the instruction of trainable children shall be paid to the district providing the special instruction and services. Foundation program aid shall be paid to the district or unorganized territory of the pupil's residence. The amount of aid for special instruction and services for trainable children may not exceed the amount for such special instruction and services for trainable children for the year for which the aid is paid.

APPENDIX F

QUESTIONNAIRE, GENERAL INFORMATION

(Completed by Directors of
Rehabilitation Therapies)

QUESTIONNAIRE, INSTRUCTIONAL PROGRAM INFORMATION

(Completed by Instructional Supervisors)

Minnesota National Laboratory
295N Griggs Midway Building
1821 University Avenue
St. Paul, Minnesota 55104

October 28, 1968

Miss Alice Ogan
Director of Rehabilitation Therapies
Brainerd State Hospital
Brainerd, Minnesota

Dear Miss Ogan:

The attached questionnaire represents an attempt to obtain certain information necessary to the completion of the Institutions Study of Educational Programs in institutions for the mentally retarded. As you know, the Minnesota National Laboratory is conducting this study, and I and other study team members have conducted site visits during the past few months.

Although we may have orally discussed a number of the items reflected in the questionnaire, we ask your indulgence in committing your ideas, judgments, and responses to writing insofar as possible.

I am requesting that you complete the attached questionnaire, and that you return it to me by November 15, 1968. I realize that this does not allow much time, but ask that you complete it to the best of your ability within this time limit.

Some of the charts we request you complete may not reflect the same age or grouping characteristics used by your institution to process and store statistical information. In completing these charts, please hold as closely as possible to the stated categories and groupings, and modify only if the data is extremely difficult to adapt to the requested format. If you need to report the general statistical information requested in a different way to more accurately reflect your information retrieval system, please modify the charts in some way and report as best you can.

Although this particular questionnaire is being sent directly to you for completion, we realize that a number of persons may have to be involved in actual collection of the data. Also, a questionnaire regarding certain specific items is being sent out under separate cover to the Instructional Supervisor in your particular institution.

If you have questions regarding the interpretation of specific questionnaire items, or if you anticipate extreme difficulty in gathering any of the requested information, please feel free to call Mr. Gordon Krantz at 935-7791, Minneapolis. He may be able to suggest appropriate modifications where indicated, and will be able to assist in clarifying as needed.

Sincerely,

Richard A. Johnson, Director
Institutions Education Programs Study

Enclosure

RAJ:sm

Minnesota State Department of Education
Minnesota National Laboratory

(______________________)
INSTITUTION

Questionnaire

GENERAL INFORMATION

INSTITUTIONS EDUCATION PROGRAMS STUDY

Minnesota State Institutions for the Mentally Retarded

(________________________)
INSTITUTION

GENERAL DIRECTIONS

This questionnaire should be completed by the Director of Rehabilitation Therapies, and returned to the Minnesota National Laboratory on or before November 15, 1968. While it may be necessary to seek the assistance of many personnel in completing Section II of this questionnaire, responses to the other major sections should be those of the Rehabilitation Therapies Director. As it may be difficult to organize your quantitative data in the same manner requested by this questionnaire, minor modification of terminology or format can be made. If you do make minor changes, please indicate how and why you made the change. If you are unable to complete any section, please indicate the reason. You may indicate this in Section VI of this questionnaire. Return one copy, the other two copies are for draft purposes and for your files.

I. RESPONDENT DATA

Report completed by ____

Your present job title: ____

What do you consider to be your major professional background (examples: occupational therapy, or industrial arts education).

____

Number of years you have worked in this Institution: __________________

Number of years as Director of the Rehabilitation Therapies Department: _______

(______________________)
INSTITUTION

II. POPULATION STATISTICS

To give us a basic understanding of this Institution's population, please secure this information on the numbers of patients in residence during each of these three years. February has been chosen to represent a single, mid-year point in each of the years. If you use a different mid-point or month, please indicate. (Extra copies of this form are provided so that you can use them as a worksheet for retrieving information within the Institution.)

Chart 1. POPULATION STATISTICS
for Feb. 1958

	AGE:					
	0-5	6-12	13-21	22-50	51+	Total
A. Total residents						
B. Non-ambulatory						
C. "Profoundly"* retarded						
D. Educable**						
E. In formal training or education program***						
F. With hearing or vision loss****						

* "Profoundly" retarded in this sense are those who need nursing care for dressing, personal hygiene, feeding, or travel within the institution; little or no communication ability.

** Educable are those whose IQ at that time was 55 or higher.

*** Formal training and education include any rehabilitation therapies program (classroom, recreation, projects like Project Teach) of a primarily educational or training nature.

**** Sensory loss sufficient to make a difference in programming of patient.

DRAW A CIRCLE AROUND THOSE NUMBERS WHICH ARE ESTIMATES

(______________________)
INSTITUTION

(II. Population statistics, continued)

Chart 2. POPULATION STATISTICS
for Feb. 1965

	AGE:					
	0-5	6-12	13-21	22-50	51+	Total
A. Total residents						
B. Non-ambulatory						
C. "Profoundly"* retarded						
D. Educable*						
E. In formal training or education program*						
F. With hearing or vision loss*						

*See definition page 2

Chart 3. POPULATION STATISTICS
For Feb. 1968

	AGE:					
	0-5	6-12	13-21	22-50	51+	Total
A. Total residents						
B. Non-ambulatory						
C. "Profoundly"* retarded						
D. Educable*						
E. In formal training or education program*						
F. With hearing or vision loss*						

*See definition page 2

DRAW A CIRCLE AROUND THOSE NUMBERS WHICH ARE ESTIMATES

(______________________)
INSTITUTION

(II. Population statistics, continued)

How many patients left your institution to some kind of community living in each of these fiscal years?

Ending June 30: 1965 ______ 1966 ______ 1967 ______ 1968 ______.

From what source(s) were you able to gather the above population statistics?

(If estimates were reported) Whose estimates were used?

Describe any difficulty you had in securing the population statistics.

(________________________)
INSTITUTION

III. POPULATION FORECAST

In this section, we are interested in what you forecast regarding your population. Please give your opinion as the director of rehabilitation therapies. With the exception of "A" below, disregard official projections, which we can obtain from other sources. If you especially recommend some other source to us, write it in below, but give your forecast also.

A. What proportion of your total institutions' residents take part in some rehabilitation therapies program? _____%. What is the upper age limit for participation in the instructional program? ________.

B. Consider the kind of person who is admitted to your institution during 1968. How long do you think institutional placement will be required for these people? Estimate proportions.

_____% one year or less
_____% two to five years
_____% five to ten years
_____% longer than ten years, or indefinitely

C. Compared to this year, do you expect the total population of your institution next year (1969) to:

_____ increase by more than 5%
_____ remain within 5%
_____ decrease by more than 5%

D. Compared to this year, do you expect the total population of your institution five years from now (1973) to:

_____ increase by more than 50%
_____ increase by 10 to 50%
_____ remain within 10% of 1968
_____ decrease by 10 to 50%
_____ decrease by more than 50%

E. What do you expect to be the age distribution of your institutions' population five years from now (1973)?

_____% under 21
_____% over 21 and under 50
_____% over 50

F. What changes would you recommend in the geographic area served by your institution in 1973, if any?

(______________________________)
INSTITUTION

IV. EXPECTATIONS

In this section, we are interested in what you see as the feasible goals for your population. Please take into account those patients who come within the scope of responsibility of your department's service (see II A. above), and base your statements upon the present population. Assume that your services will be as effective as you know how to make them.

A. Community competence. What percentages of the patients with whom your department deals have potential for eventually reaching each of these levels of community competence? "Eventually" can be some time from now, but assume that the demands of community living will not have changed.

_____% potential for fully independent living in the community, with only routine agency contacts and normal family relationships

_____% potential for semi-independent living, such as being dependent in own family, or for group living in a community facility for the retarded

_____% potential for full dependence only, in need of 24-hour care or supervision

B. Personal satisfaction and fulfillment. What proportion of the patients with whom you now deal have the potential for reaching each of these levels of satisfaction and fulfillment? Disregard how you would feel in their position, or how well a non-retarded person would adapt to the life circumstances (in the community or in the institution) faced by the people with whom you deal.

_____% more satisfied and more self-fulfilled than the average person

_____% will feel as satisfied and as self-fulfilled as does the average person

_____% will feel more dissatisfied and unfulfilled than does the average person

_____% will feel chronically dissatisfied and unfulfilled

_____% lack the capacity to relate to life in terms of satisfaction and self-fulfillment

(______________________)
INSTITUTION

(IV. Expectations, continued)

C. Occupation. This includes the full range of using time to satisfactory and, if possible, productive ends. Please estimate the proportions of patients with whom you deal who have the following occupational potentials.

_____% have potential for competitive employment. This is employment at ordinary wages and under ordinary conditions in competition with normal employees. It includes work done by individuals who live in the community and competitive work done off the hospital grounds for private employers by persons who continue to domicile in the institution. It also includes civil service employees who continue to reside in the hospital.

_____% have potential for sheltered employment. This is employment under circumstances which take into account the person's handicap and is authorized by the Federal Wages and Hours Division to pay less than the minimum wage. It is usually provided in a sheltered workshop. Again, the worker may live in the community, or he may domicile in an institution and work at a workshop off the institution grounds, or the institution may provide its own sheltered employment. The worker in sheltered employment must be able to produce work worth at least 75¢ an hour.

_____% have potential to engage in work activity or productive daytime activity. This is employment at more than zero and less than 75¢ an hour and is licensed by the Federal Wages and Hours Division. From the legal standpoint, it is a kind of sheltered employment.

_____% have potential to engage in adult daytime activity. This is occupation in meaningful, purposeful activity of the kind which constructively occupies the person's day. However, it does not earn a wage. It is provided by a few community daytime activity centers and could be provided in an institutional setting.

_____% lack the potential for any kind of meaningful daytime activity or occupation.

(______________________)
INSTITUTION

V. DIAGNOSTIC AND CASE MONITORING PROCEDURES

In this section we are interested in learning about the diagnostic system, the transmittal of case information within rehabilitation therapies and across department lines, and with the development of individual case actions.

A. What diagnostic procedures are carried out by, or at the case-by-case request of, the rehabilitation therapies personnel? Disregard here those procedures which are an institution-wide routine part of every patient's case study and which are initiated outside your department. Incluse standard psychological testing if carried out at the request of your department. If unstandardized or "home grown" procedures are used, please identify them well enough so that we can understand what they are. Place a conspicuous checkmark beside those procedures which are primarily educational in nature. Use reverse side of this page if necessary.

B. How much of a case file is maintained within the rehabilitation therapies department? Check the most appropriate statement below:

_____ no case file as such maintained in rehabilitation therapies; institution has a case file housed elsewhere

_____ single case file maintained in rehabilitation therapies department; file used routinely by all sections of the department; usual contents described below

_____ case files maintained separately by individual sections within the rehabilitation therapies department; typical education (Instructional Program) file described below

_____ other:

(______________________)
INSTITUTION

(V. Diagnostic and case monitoring procedures, continued)

C. In this section, we are interested in the information available to your education (Instructional Program) section and actually used by them. In "education" please include classrooms as well as any other programs which you identify as being primarily education. Since we will probably have failed to mention all the possible information, please feel free to add comments after checking all the blanks below which apply. Check only those to which education personnel have routine access.

_____ central institution case file on patient

_____ abstracts from central institution case file, such as psychological reports filed in the rehabilitation therapies department

_____ rehabilitation therapies case file

_____ files and reports of other education personnel in the department

_____ educators' own file only

_____ oral or written progress reports made by others in rehabilitation therapies

_____ staff conferences

D. What written reports bearing on individual patient status and progress are routinely made by the education (Instructional Program) personnel? To whom are they routed?

E. What oral reports of patient's status and progress are made routinely by the education (Instructional Program) personnel? To whom are these reports made:

(________________________)
INSTITUTION

(V. Diagnostic and case monitoring procedures, continued)

F. To the extent that educational programs of patients are individually designed:

1. How are the educational "prescriptions" derived?

2. Who participates in the decision? If some individual carries final responsibility in this decision, who is he?

3. What record is kept of these decisions and individualized programs?

(_______________________)
INSTITUTION

VI. PROGRAM REQUIREMENTS

A. Please describe what your particular institution and Department needs in order to conduct an educational program as well as you know how. Please be general. For example, if certain kinds of equipment are needed, do not provide a listing but rather describe the general kind. If personnel, describe the general kinds rather than bothering with exact numbers. If organizational changes are needed and suggested by you, please do not make them dependent upon individual personalities. Attach additional pages as necessary.

Thank you for gathering the information requested in this questionnaire. We may have overlooked some items or classes of information which you know to be essential to understanding your program. Please feel free to add anything you would like to have us know, even if you have previously discussed this orally with members of the Minnesota National Laboratory Study Team. Add this information in the next section, Section VII. Please return this form by November 15, 1968 to:

Minnesota National Laboratory
Room 295N Griggs-Midway Building
1821 University Avenue
St. Paul, Minnesota 55104
Attn: Mr. Richard Johnson

(________________________)
INSTITUTION

VII. COMMENTS AND SUGGESTIONS

VIII. ATTACHMENTS

Please attach to this questionnaire copies of the following documents. Please clearly mark those which are single-copy or which, for other reasons, you must have returned to you.

Policy or operations guides, or documents which give other general information, relating to

Rehabilitation Therapies
Instructional Program

Copies of all Federal projects which have been funded in the past five years, or which are currently in operation.

An up-to-date organizational chart for the Rehabilitation Therapies Department, including all of the instructional programs and programs which could be reasonably so classified. Please modify to reflect current actual function.

Chart listing present staff positions and incumbents. See sample format attached.

Current salary schedules for (1) your institution and (2) local school district.

Other documents which you feel would be of use to the Study Team.

INSTITUTION

STAFF ROSTER[1]

REHABILITATION THERAPIES DEPARTMENT

SAMPLE FORMAT

	NAME	TITLE	BIRTHDATE	TRAINING[2]	CERTIFICATION[3]	# YRS. AS TEACHER OR THERAPIS	# YRS. AT CAMBRIDGE	COMMENTS
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								

---

[1] Include any person with patients in any formal program, regardless of degree or certification. Do not, however, list "Project Teach" non-professional personnel.

[2] List degrees held major and minor fields, add any additional specialized training.

[3] List only Minnesota Department of Education Certification. List all certificates held.

Minnesota National Laboratory
295N Griggs Midway Building
1821 University Avenue
St. Paul, Minnesota 55104

October 28, 1968

Mr. Darrell Stave
Instructional Supervisor
Brainerd State Hospital
Brainerd, Minnesota

Dear Mr. Stave:

Enclosed with this letter is a questionnaire which we are asking that you complete. Completion and return of this questionnaire represents the final data collection step necessary to complete the Institutions Education Programs Study.

Please return this questionnaire to us on or before November 15, 1968. If you have questions regarding specific sections, please call Mr. Gordon Krantz at Minneapolis, 935-7791 for clarification.

We appreciate your cooperation in this matter, and recognize that this will take time away from your already busy schedule. Let me thank you in advance for any efforts you may expend in completing this questionnaire.

Sincerely,

Richard A. Johnson, Director
Institutions Education Programs Study

Enclosure

RAJ:sm

Minnesota State Department of Education
Minnesota National Laboratory

(______________________)
INSTITUTION

Questionnaire

INSTRUCTIONAL PROGRAM INFORMATION

INSTITUTIONS EDUCATION PROGRAMS STUDY

Minnesota State Institutions for the Mentally Retarded

(______________________)
INSTITUTION

GENERAL DIRECTIONS

This questionnaire should be completed by the Instructional Supervisor and returned to the Minnesota National Laboratory on or before November 15, 1968. If you are unable to respond to a particular question or section, leave blank and indicate the reason in the "comments" section of the questionnaire. Return one copy. The other two copies are for draft purposes and for your files.

I. RESPONDENT DATA

Report completed by ______________________________

Your present job title: ______________________________

What do you consider to be your major professional background (examples: special education, psychology, industrial arts education).

____

Number of years you have worked in this Institution: ______________

Number of years as Instructional Supervisor: ______________

List the instructional activities which come under your supervision:

(______________________)
INSTITUTION

Note: In the following sections of this questionnaire, some of the questions are similar to those which are asked of the Director of the Rehabilitation Therapies Department. Do not let that fact confuse you or him, and do not expect that your answers should agree. There should be at least two sources of difference. First, you are being asked about participants in the instructional program only; this is not the same as particpants in all the sections of Rehabilitation Therapies, which is a larger number. Second, where opinion is asked, we could hardly expect that two people would be in complete agreement.

II. EXPECTATIONS

In this section, we are interested in what you see as the feasible goals for your population. Please take into account those patients who come within the scope of responsibility of your department's service (see II A. above), and base your statements upon the present population. Assume that your services will be as effective as you know how to make them.

A. Community competence. What percentages of the patients with whom your department deals have potential for eventually reaching each of these levels of community competence? "Eventually" can be some time from now, but assume that the demands of community living will not have changed.

_____% potential for fully independent living in the community, with only routine agency contacts and normal family relationships

_____% potential for semi-independent living, such as being dependent in own family, or for group living in a community facility for the retarded

_____% potential for full dependence only, in need of 24-hour care or supervision

B. Personal satisfaction and fulfillment. What proportion of the patients with whom you now deal have the potential for reaching each of these levels of satisfaction and fulfillment? Disregard how you would feel in their position, or how well a non-retarded person would adapt to the life circumstances (in the community or in the institution) faced by the people with whom you deal.

_____% more satisfied and more self-fulfilled than the average person

_____% will feel as satisfied and as self-fulfilled as does the average person

_____% will feel more dissatisfied and unfulfilled than does the average person

_____% will feel chronically dissatisfied and unfulfilled

_____% lack the capacity to relate to life in terms of satisfaction and self-fulfillment

(______________________)
INSTITUTION

(II. Expectations, continued)

C. Occupation. This includes the full range of using time to satisfactory and, if possible, productive ends. Please estimate the proportions of patients with whom you deal who have the following occupational potentials.

_____% have potential for competitive employment. This is employment at ordinary wages and under ordinary conditions in competition with normal employees. It includes work done by individuals who live in the community and competitive work done off the hospital grounds for private employers by persons who continue to domicile in the institution. It also includes civil service employees who continue to reside in the hospital.

_____% have potential for sheltered employment. This is employment under circumstances which take into account the person's handicap and is authorized by the Federal Wages and Hours Division to pay less than the minimum wage. It is usually provided in a sheltered workshop. Again, the worker may live in the community, or he may domicile in an institution and work at a workshop off the institution grounds, or the institution may provide its own sheltered employment. The worker in sheltered employment must be able to produce work worth at least 75¢ an hour.

_____% have potential to engage in work activity or productive daytime activity. This is employment at more than zero and less than 75¢ an hour and is licensed by the Federal Wages and Hours Division. From the legal standpoint, it is a kind of sheltered employment.

_____% have potential to engage in adult daytime activity. This is occupation in meaningful, purposeful activity of the kind which constructively occupies the person's day. However, it does not earn a wage. It is provided by a few community daytime activity centers and could be provided in an institutional setting.

_____% lack the potential for any kind of meaningful daytime activity or occupation.

(______________________)
INSTITUTION

III. BUDGET AND FINANCE

This section refers to the funding of the instructional section of your Institution. Include in your consideration all the instructional activities which you listed as being under your supervision.

A. What are all the sources (federal, state, local school, donations, etc.) of the funds used to carry out the instructional program? Be as specific as you can. For example, if Federal funds are used, please specify which fund, such as "PL 89-10, Title VI".

SOURCE	AMOUNT LAST YEAR	COMMENTS

B. What was the total amount budgeted for allocation to the instructional program including salaries, supplies, equipment, and other expenses:

Fiscal year 1966-67 ______________

Fiscal year 1967-68 ______________

Fiscal year 1968-69 ______________

C. What were the actual expenditures for the instructional program

Fiscal year 1966-67 ______________

Fiscal year 1967-68 ______________

D. What major "project" or special-purchase expenditures were made in the instructional program during fiscal years 1966-67 and 1967-68?

Check one: ___ included in above figures; ___ not included above.

Nature of expenditure(s)	Source of Funds	Amount

(________________________)
INSTITUTION

E. Budget plans usually have to be made well in advance. Some budgets, once approved, become quite fixed; funds allocated to one line item cannot be readily transferred to use for another item. Other budgets are quite flexible, in that there is much freedom to change allocations within the total amount.

1. What are the categories or lines in which the instructional budget for your program is stated at the time of its annual or biennial approval?

2. When you, at your level of administration, wish to make a transfer of fund allocation between two of the categories you have just listed during the course of the fiscal year, what steps do you follow? Indicate which are in writing.

F. Any remarks which you would like to make regarding budget and finance:

(________________________)
INSTITUTION

IV. INSTRUCTIONAL PERSONNEL

Consider all personnel assigned to the instructional activities under your supervision. Include your own position. For any personnel who are assigned part time to instructional duties, consider that portion of time which is under your supervision.

A. Personnel positions existing at this time:

POSITION	NO. POSITIONS	NO. FILLED
Administrative and consulting	____________	__________
Teachers, certificated (certif. required)	____________	__________
Teachers, non-certificated	____________	__________
Clerical	____________	__________
Other (specify titles below)	____________	__________
	____________	__________
	____________	__________

B. If positions at this time are unfilled: what, in your opinion, is the problem?

C. What consulting services have you received from the State Department of Education in the past two years? Give type of contact (visit by, letter, phone, etc.) and subject of consultation, position of person giving consultation, and approximate date, if possible.

(______________________________)
INSTITUTION

G. What are your in-service training plans for this year?

H. What has been the participation in professional meetings and conferences by staff of the instructional program during the past two years? Indicate type of meeting, where held, positions and numbers of participants from your program, and the nature of their participation (auditor, scheduled speaker, etc.).

(______________________)
INSTITUTION

I. Give enrollment of instructional staff in college courses for credit in subjects related to their work. Indicate position titles, subject, credits.

School Year 1967-68

Summer 1968

School Year 1968-69

J. What site visits to other programs have been made by instructional staff during the past two years? Please indicate location and type of program, staff making visit, duration of visit, kind of report brought back (attach copy of duplicated). Give your evaluation of this kind of visit if you wish. Make a conspicuous check mark beside those for which expense reimbursement, such as mileage or lodging, was not available from state funds.

(____________________)
INSTITUTION

V. STUDENTS AND STUDENT PROGRAMMING

A. What proportion of the total patients of your hospital take part in the instructional program identified above and under your supervision? ____%

B. What proportion of the patients who take part in any of the Rehabilitation Therapies program are currently participants in the instructional program? ____%

C. How many patients are currently participating in the instructional program? ____

D. What are the age limits for participation in the instructional program? ____

E. What other requirements are established by policy for participation in the instructional program? ____

____.

F. Please give the numbers of patients who participate in the instructional program whom you would classify in these categories. Your numbers need not agree with anyone else's classification.

Not retarded ____

Educable retarded ____

Trainable retarded ____

Below trainable ____

Define any of these terms, to your own satisfaction, below. Feel free to change the classification as long as you make clear your meaning.

G. Please give approximate number of patients who are currently in instructional programs for the following proportions of the day.

Full day (5 or more hours) ____

Half day ____

One-fourth day ____

Less than one-fourth day ____

(______________________)
INSTITUTION

H. How is the decision made that a given patient should participate in the instructional program?

I. What is the age distribution of current participants in the instructional program? Feel free to change these age ranges so as to correspond to your system of age records.

AGE RANGE	NO. PARTICIPANTS
0-5	________
6-12	________
13-20	________
21 - over	________

J. How is the content of an individual patient's instructional program determined? Please identify the kinds of information upon which the determination is based, the staff member(s) who make the determination, whether the determination is made as a group decision or individually, and who, if anyone, carried final decision responsibility.

(______________________________)
INSTITUTION

K. What record is made of the determination of an individual patient's instructional program? Attach a representative example.

L. How are changes in the patient's instructional program determined? What record is made? Attach a representative example.

M. What patient records, other than those generated within the instructional program, are regularly or routinely viewed by the instructional staff?

(_________________________)
INSTITUTION

N. What reports of patient status or progress are routinely made by the staff of the instructional program to persons outside the instructional program? If written, or if oral at a conference where notes are taken or entered in case record, please attach a representative example.

O. Please list tests and instruments used to measure patient achievement or progress in the instructional program. If unstandardized or "home grown" devices are used, please identify them well enough so that we can understand what they are.

(______________________)
INSTITUTION

VI. PROGRAM REQUIREMENTS

A. Please describe what your particular institution and Department needs in order to conduct an educational program as well as you know how. Please be general. For example, if certain kinds of equipment are needed, do not provide a listing but rather describe the general kind. If personnel, describe the general kinds rather than bothering with exact numbers. If organizational changes are needed and suggested by you, please do not make them dependent upon individual personalities. Attach additional pages as necessary.

Thank you for gathering the information requested in this questionnaire. We may have overlooked some items or classes of information which you know to be essential to understanding your program. Please feel free to add anything you would like to have us know, even if you have previously discussed this orally with members of the Minnesota National Laboratory Study Team. Add this information in the next section, Section VII. Please return this form before November 15, 1968 to:

Minnesota National Laboratory
Room 295N Griggs-Midway Building
1821 University Avenue
St. Paul, Minnesota 55104
Attn: Mr. Richard Johnson

(____________________)
INSTITUTION

VII. COMMENTS AND SUGGESTIONS

VIII. ATTACHMENTS

Please attach to this questionnaire copies of the following documents. Please clearly mark those which are single-copy or which, for other reasons, you must have returned to you.

Policy or operating guides, or documents which give other general information, relating to

Rehabilitation Therapies
Instructional Program

Copies of all Federal projects which have been funded in the past five years, or which are currently in operation.

An up-to-date organizational chart for the Rehabilitation Therapies Department, including all of the instructional programs and programs which could be reasonably so classified. Please modify to reflect current actual function.

Current salary schedules for (1) your institution and (2) local school district.

Other documents which you feel would be of use to the study team.

APPENDIX G

ABSTRACTS OF SELECTED LEGISLATION RELATED TO FUNDING OF RESEARCH AND PROGRAM PLANNING EFFORTS

ABSTRACTS OF SELECTED LEGISLATION RELATED TO FUNDING OF RESEARCH AND PROGRAM PLANNING EFFORTS

The data contained in this Appendix represents selected Federal and State programs which relate to the needs of the institutionalized mentally retarded, and which address primarily to legislation in support of research, planning and demonstration. This Appendix includes a compilation and editing of data from many written sources, and information received in consultation with Federal and State officials.

It would be quite presumptuous and inaccurate to assume that a complete list of legislative programs which may provide assistance to the mentally retarded is included in this appendix. The nature and interpretation of Federal and State law is such that any person, group, or institution may receive assistance in accordance with this right by congressional action so stated in the law or subsequent amendments. Consequently, much additional legislation could be considered if the services rendered under the provisions of the act were relevant to the needs of the mentally retarded.

For those persons responsible for the care, treatment, and education of the mentally retarded children and adults, the needs are broad and all encompassing. State financial support, in general, provides for the basic necessities of institutions, but contributes little to the development of the supportive services, research, and the innovative studies imperative to the improvement and progress of such programs. Federal assistance, on the other hand, provides little basic support for these institutions, but focuses upon those areas of concern which demand additional resources for innovation, planning, demonstration, and research.

For the most part, the research-related financial assistance programs summarized herein are administered by agencies in the U.S. Department of Health, Education and Welfare. The responsibilities of Federal and State departments and agencies sometimes overlap in their support of programs for the mentally retarded within the confines of their specific functions. For example, the Department of Interior is charged with the welfare of the Indian population in respect to their total needs, the Office of Economic Opportunity responds to the critical needs of the impoverished, and Medicare provides some support for the aged.

As National priorities, legislative changes, annual appropriations, and other factors tend to create a degree of uncertainty in the availability of funds of many Federal programs, the abstract contained in this appendix will only be useful as basic references for summary information. These factors emphasize the need for close cooperation and communication with Federal and State administrators both before and as projects are developed. The data included for each abstract in this appendix will provide the following types of information:

1. Legislative authority.
2. Program title.
3. Purpose and summary.
4. Basic provisions.
5. Eligible applicants.
6. a. Application procedure.
    b. Deadline dates.
    c. Limitations.
    d. Matching provision.
7. Available provision.
8. Fiscal disbursement procedures.
9. Administering agency.

It is important that these analyses are up-dated periodically to assure maximum utility. Again, there are a number of laws which have not been abstracted which have reference to meeting the needs of the mentally retarded. This listing is not intended to be comprehensive or all-inclusive, and should be viewed within that context.

RESEARCH AND PLANNING FUNDS ABSTRACTS

A. Program:

Research in the Educational Improvement of the Handicapped.

Authority:

Mental Retardation Facilities and Community Mental Health Centers Construction Act (P. L. 88-164, Title III, Section 302.)

Purpose:

To support research in the education, physical education, and recreation of the handicapped (primarily children and youth). The "handicapped" include those who are mentally retarded, hearing impaired, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or otherwise health impaired and requiring special education.

Eligible Applicants:

State agencies, public and private schools, colleges, universities, institutions, and other organizations.

Application Procedures:

1. No deadline dates.
2. No funds for construction under this title and section.
3. Cost-sharing is generally expected of granters.
4. Applications are submitted to the "Administering Agency."

Administrative Agency:

Projects and Programs Research Branch Division
Division of Research
Bureau of Education for the Handicapped
U. S. Office of Education, R O B
Washington, D. C. 20202

B. Program:

Cooperative Research Program.

Authority:

Cooperation Research Activities (P. L. 83-531 as amending by P. L. 89-10, Title IV and others).

Purpose:

This program in its intial year of operation designated two-thirds of the total appropriation for research of educational programs for the mentally retarded. More recent legislation enacted for this purpose has broadened the scope of the Cooperative Research. Mental retardation remains an area of concern under this legislation. It supports research, surveys, and demonstrations in the field of education for the purpose of developing new knowledge about major problems in education.

Eligible Applicants:

Universities, colleges, state and local education agencies, both profit and non-profit institutions, and individuals.

Application Procedures:

1. Application forms and instructions may be obtained from the Research Analysis and Allocation Staff, Bureau of Research, U. S. Office of Education.
2. There are no deadline dates.

Fiscal Disbursement Procedures:

1. Direct grants made by the U. S. Office of Education to the applicant of an approved project.
2. Matching funds are required, but in no specific percentage.
3. Payments are based on the proposal budget and made by installments, in advance, or by reimbursement.

Administrative Agency:

Bureau of Research
U. S. Office of Education
400 Maryland Avenue, S. W.
Washington, D. C. 20202

C. Program:

Cooperative Research Small Grant Program.

Authority:

Cooperative Research Activity (P. L. 83-531 as amended by P. L. 89-10, Title IV and others).

Purpose:

The purpose of the Small Grant Research Program is to encourage those smaller institutions who are less active in the field of research to develop competencies and personnel which will further enhance the improvement of education. The general purposes are the same as those in the large grant program. Grants for graduate students are available. No grant may exceed $10,000. The program is administered through the Regional Offices of the Department of Health, Education and Welfare.

Application Procedures:

Application forms and instructions may be obtained from the Research Analysis and Allocation Staff, Bureau of Research, U. S. Office of Education, or from the regional office of the Department of Health, Education and Welfare in Kansas City, Missouri.

Fiscal Disbursement Procedures:

1. Direct grants made by the U. S. Office of Education to the applicant of an approved project.
2. Matching funds are required, but in no specific percentage.
3. Payments are based on the proposal budget and made by installments, in advance, or by reimbursement.

Administrative Agency: (for Minnesota)

Director of Educational Research
Office of Education / DHEW
Region VI, Regional Office
Kansas City, Missouri

D. Program:

Hospital and Medical Facilities Research and Demonstration Program.

Authority:

Hospital and Medical Facilities Survey and Construction Act of 1946 (Hill-Burton Act. P. L. 79-725, Section 2).

Purpose:

To support research and demonstration projects relating to the development, use and coordination of hospital services and facilities.

Eligible Applicants:

States, political sub-divisions, institutions of higher education, hospitals, and other public and private non-profit institutions and organizations.

Application Procedures:

1. Applications should be sent to:

   Division of Research and Grants
   National Institutes of Health
   Bethesda, Maryland 20014

2. Deadline dates are: February 1, June 1, and October 1, of each year.
3. There is no formal requirement for cost-sharing. More than token support is expected from the applicant.

Administering Agency:

General information, grant development materials and application forms (P H S -398) may be obtained from:

Division of Hospital and Medical Facilities
Public Health Service, DHEW
Washington, D. C. 20201

E. Program:

Mental Retardation Project Grants.

Authority:

Public Health Service Act of 1944 (P. L. 78-410, as amended).

Purpose:

To stimulate the development or demonstration of community activities to identify and to provide services to the mentally retarded who are retained in the community, and to expedite the return to the community of retarded individuals who can benefit from home experiences.

Eligible Applicants:

State or local public agencies, non-profit private agencies, institutions, or organizations.

Application Procedure:

For further information contact the administering agency.

Administering Agency:

Mental Retardation Branch,
Division of Chronic Diseases,
Public Health Service
U. S. Department of Health, Education and Welfare
Washington, D. C. 20201

F. Program:

National Institute of Mental Health Project Grants

Authority:

Public Health Services Act of 1944 (P. L. 78-410, as amended).

Purpose:

To support experiments, demonstrations, and studies designed to improve methods of care, treatment, and rehabilitation of the mentally ill and mentally retarded, to develop methods for prevention of mental illness and of mental retardation, and to initiate or strengthen programs to promote better mental health. This program includes the Hospital Improvement Program.

Eligible Applicants:

State or local agencies; laboratories; other public or non-profit agencies; public institutions for the mentally retarded; individuals.

Application Procedure:

For further information contact the Administering Agency.

Administering Agency:

Mental Health Project Grants Section
Community Research and Services Branch
National Institute of Mental Health, Public Health Service
U. S. Department of Health, Education and Welfare
Bethesda, Maryland 20014

G. Program:

Demonstrations in the Educational Improvement of the Handicapped.

Authority:

Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P. L. 88-164, as amended).

Purpose:

To support demonstrations in the education, physical education, and recreation of the handicapped which includes those who are mentally retarded, seriously emotionally disturbed, or otherwise health impaired and requiring special education.

Eligible Applicants:

State agencies, public and private schools, colleges, universities, institutions, and other organizations.

Application Procedures:

1. No deadline dates.
2. The activity must have general (not purely local) applicability, and be directed toward communicable results.
3. No matching requirements.
4. Applications are submitted to the administering agency.

Administering Agency:

Research Laboratories and Demonstration Branch
Division of Research
Bureau of Education for the Handicapped
U. S. Office of Education, R O B
Washington, D. C. 20202

H. Program:

National Institute of Child Health and Human Development Research Grants.

Authority:

Public Health Services Act (P. L. 78-410, as amended).

Purpose:

To stimulate and support scientific investigations in mental retardation and related aspects of human development.

Eligible Applicants:

Medical schools, hospitals, colleges, universities, and institutions on behalf of qualified investigators.

Application Procedures:

For further information contact the administering agency.

Administering Agency:

Division of Research Grants
National Institute of Health
Public Health Services, DHEW
Bethesda, Maryland 20014

I. Program:

Research Grants for Maternal and Child Health and Crippled Children's Services.

Authority:

Social Security Act of 1935 (P. L. 74-271, Title V, Part 4, Section 533 as amended).

Purpose:

For research projects relating to maternal, child health, crippled children's services and health services for mentally retarded children.

Eligible Applicants:

Public or private non-profit institutions, universities, colleges, and organizations engaged in research or in maternal and child health, mental health, and crippled children's programs.

Application Procedures:

For further information contact the administering agency.

Administering Agency:

Division of Research
Children's Bureau
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

J. Program:

Child Welfare Research and Demonstration Grants.

Authority:

Social Security Act of 1935 (P. L. 74-271, Title V, Part 4, Section 533 as amended).

Purpose:

For special research and demonstration projects of national significance in the field of child welfare, and special projects for the demonstration of new methods or facilities promising substantial contribution to the advancement of child welfare. Demonstration projects may deal with the deprived child, mental retardation, and other areas.

Eligible Applicants:

Public and private non-profit institutions, universities, colleges, agencies, and organizations engaged in research or child welfare activities.

Application Procedures:

For further information contact the administering agency.

Administering Agency:

Division of Research
Children's Bureau
Social and Rehabilitation Services, DHEW
Washington, D. C. 20201

K. Program:

Maternal and Child Health Services.

Authority:

Social Security Act of 1935 (P. L. 74-271, Title V, Part 1, Section 526 as amended).

Purpose:

For special projects of regional and national significance which may contribute to the advancement of maternal and child health, especially in rural and low-income areas. Study projects relating to mental retardation services are included.

Eligible Applicants:

State health agencies, public or private; non-profit junior colleges, colleges, and universities.

Application Procedures:

For further information contact the administering agency.

Administering Agency:

Regional Medical Director
Children's Bureau
Regional Office VI, DHEW
Kansas City, Missouri 64106

or

Division of Health Services
Children's Bureau
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

L. Program:

Services for Crippled Children.

Authority:

Social Security Act of 1935 (P. L. 74-271, Title V, Part 2, Section 526, as amended).

Purpose:

To extend and improve, especially in rural and low income areas, services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care, for children who are crippled or who are suffering from conditions which lead to crippling. Special project of regional or national significance which may contribute to the advancement of services for crippled children may deal with mental retardation and handicapping conditions, such as cystic fibrosis, nephrosis, epilepsy, hearing impairments, neurological defects, and impairments at birth. Project grants may also provide for follow-up care and special studies of services to mentally retarded and multi-handicapped children.

Eligible Applicants:

State crippled children agencies, and public or private non-profit junior colleges; and universities.

Application Procedures:

For further information contact the administering agency.

Administering Agency:

Regional Medical Director
Children's Bureau
Regional Office VI, DHEW
Kansas City, Missouri 64106

or

Division of Health Services
Children's Bureau
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

M. Program:

Research and demonstration grants (Social and Rehabilitation Service).

Authority:

Vocational Rehabilitation Act of 1954 (P. L. 83-565, Section 4, (a) (1)).

Purpose:

For research projects intended to contribute new knowledge, principles, techniques, or devices to the field of Vocational Rehabilitation; and for demonstration projects which apply results retained from research to developing and evaluating the effectiveness of new rehabilitation procedures. Project areas include medicine (and its related fields), psychology, counseling and guidance, speech pathology, and audiology, sociology, anthropology, etc.

Eligible Applicants:

Public and private schools, institutions of higher education, State Vocational Rehabilitation Agencies, and other public and private non-profit agencies and organizations which may effectively utilize or demonstrate improved devices or procedures in vocational rehabilitation.

Application Procedures:

1. Applicants must consult with the State Vocational Rehabilitation agency in the planning and development stages of research and demonstration projects.
2. State Vocational Rehabilitation agencies must approve any applications which plan to provide direct services to handicapped persons.
3. Applications are submitted to the administering agency.

Administering Agency:

Division of Research Grants and Demonstrations
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

(Applicant must submit information copies to the Social and Rehabilitation Service Regional Representative and to the Director of the State Vocational Rehabilitation Agency.)

N. Program:

Rehabilitation Research and Training Centers.

Authority:

Vocational Rehabilitation Act (P. L. 83-565, Section 4 (a) (1), as amended).

Purpose:

To provide grants to universities and institutions for research and training centers in mental retardation providing a continuing framework of psychological, social, vocational and rehabilitation research and training. These institutions must have a program for research and training of professional workers in the field of mental retardation; have a stable, well-trained professional staff capable of rendering a high standard of comprehensive care and service to the mentally retarded, and of conducting an excellent quality of research and training; and have an effective program of supervision of care and services, research, and training.

Application Procedures:

1. Applicant must consult and coordinate with the State Vocational Rehabilitation agency.
2. Deadline dates are March 1, July 1, and November 1.
3. Applications are submitted to the administering agency.

Administering Agency:

Division of Research and Training Centers
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

O. Program:

Research Project Grants.

Authority:

Public Health Service Act (P. L. 78-410 as amended and P. L. 88-206, as amended).

Purpose:

To establish, expand, and improve activities into health sciences and related fields. Projects may consist of laboratory, clinical, population, fields, statistical, basic, applied, or other types of investigations including all areas of mental health and mental retardation.

Application Procedures:

1. Matching funds are not required, however, a reasonable share of project costs are to be met by the institution.
2. The following subject areas have Review Groups established in the Public Health Service:
    - a. Mental Health Project Grant - Special areas.
    - b. Mental Health Project Grant - Hospital improvement.
    - c. Mental Health for Juvenile Delinquency.
    - d. Mental Health Small Grants.
    - e. Mental Health Special Grants.

Administering Agency:

Grant Application and Document Control Office
Public Health Service
9000 Rockville Pike
Bethesda, Maryland 20014

APPENDIX H

PROJECT TEACH

PROJECT TEACH

Project Teach is the code name of a learning program conducted at the Faribault and Cambridge State Hospitals. It is funded under Title I (P. L. 89-10 and 89-313, The Elementary and Secondary Education Act)..

The direct service staff of Project Teach consists of community residents employed half-time. They are given inservice training and are supervised by the residential nursing and rehabilitation therapy staff. The intent has been to employ people who are interested in the project and are able to do the work of the project, and to assist ward nursing staff in further developing the program. It was apparent that employment of full time people would unnecessarily cut into the local market for psychiatric technicians. The premise of this plan is that "the institution should be able to employ people from the community on a part-time basis just as though a grocery store owner would employ part-time check-out counter girls." Salary is based on the competitive local labor market rate.

Project Teach is addressed to the most severely retarded and multiple handicapped children in the institution. The Project is designed to include all of the patients living within the designated Project buildings. Planning includes all aspects of care and services on the basis of 24-hour per day, 7 days per week. The intent is that the Project should have a substantial impact on the entire life style of the children. As a beginning step toward higher level of social functioning and as the child gets older, the project is intended to be a kind of head-start program. It is anticipated that over a period of several years of intensive programming, the institutions can obtain information and experience necessary in determining what is important in changing the life style of severely handicapped children.

Knowledge and past experience in programming for retarded children indicated to the institutions that all aspects of the residential living and learning situation should be directly related to Project success. For that reasons, matters related to the ability to use furniture, to getting along with others, to playing and using toys, and to the stimulation of room color and design in small secure activity areas are important considerations of the Project. Since most patient buildings are of the large ward-type room variety, it was necessary to create small living units within the building so that children would have an opportunity to identify with peers and to play and learn in small groups.

Small groups of patients are dealt with in Project Teach. The patient-staff ratio is such that a given "teacher" has no more than about 6 patients at one time. Dress and personal appearance are considered quite important. Therefore the Project will, if necessary, pay for any additional clothing needed over and above that which the institution is able to provide. Although the institution and relatives are usually able to provide all necessary clothing, it sometimes happens that they are not. Children's clothing helps them to identify themselves as individuals, and are intended to be varied in color and design as well as to fit properly.

The Project is viewed as one which requires modification of services according to the particular needs of the most severely retarded patients in Project groups. For this reason, children are not selected on the basis of ability to fit into the Project, but rather Project services are determined on the basis of group and individual needs.

The Project is also addressed to determining what can be done within the existing large and in some cases, outdated patient buildings. A large portion of the Project budget went initially for purchase of equipment such as furniture and cabinets.

The proposal for Project Teach stated that, "We have, through the course of years of experience, learned that patients will respond to these kinds of services if they are intensively programmed on an organized basis for sufficiently long periods of time. This has been shown by many attempts by institution staff through the programs they were able to provide even with insufficient staff. By the same token we have found that two or three hours per week of recreation activity for severely retarded patients without other types of learning situations has virtually no impact on social development of patients. We know that patients do not learn to eat unless they are taught to do so. We also know that we need staff to teach patients how to use the bathroom, take a bath, brush their teeth, play with toys, etc. Teaching involves more time and patience than does custodial care." With the usual shortage of staff on patient wards, it had become virtually routine to brush the patient's teeth, wash his face, change his diaper, and feed him rather than to teach him to do these things for himself. From past experience in other institutional projects, for example the feeding program at Faribault State School and Hospital, the project framers were convinced that most severely retarded patients can learn to feed themsevles. Results of a project at the Brainerd State School and Hospital (also Title I, Elementary and Secondary Education Act) indicated that small activity groups (which use college students as group leaders) have an impact on the most severely retarded children when placed in a learning situation. "These children look differently, act differently, adapt to the situation, and learn to play with other children at least to some degree," states a DPW memorandum of February 21, 1967.

The memorandum goes on to say, "These are not new discoveries, nor is the Project addressed to proving that these factors are necessary to raising the functional ability of children; we know that they do. What we want to demonstrate is that all these activities programmed together in a continuous day-to-day living and learning situation will have lasting effect in the development of retarded children. Hopefully, this Project will reverse the life style of the patients so that as he gets older we will be capable of adapting and adjusting to home, community, and institutional living. It is predictable that he will be more self-sufficient and easier to care for."

The aims stated for the Project in 1967 were to demonstate that, 1) patients can learn and as a result, can be raised to a higher level of functioning, 2) there is a cost element that can be attached to a given unit of patients in order to provide a similar kind of program for other groups and 3) cost can be estimated in terms of dollars, staff, community involvement, and emotional investment in the children.

At inception it was acknowledged that the Project would be difficult to evaluate in terms of known testing techniques. Much of the evaluation is based on observation, anecdotal records and progress reports about patient behavior of parents, interrelationship with others, and ability to function in a variety of organized learning activities. Provision was made for a series of movie films taken prior to the Project, during the Project and at the end of the Project in order to establish a level of attainment.

At Faribault, Project Teach served 239 students as of November 1, 1968. Each of those patients was programmed to a full 8 hour day. Of the 239, 1 was under age 6, 127 between the ages of 6 and 12, and 111 between the ages of 13 and 20. 32% of all Faribault patients below the age of 21 were enrolled in Project Teach. The 8 hour instruction in Project Teach contrasts with the 1½ to 2 hours of daily program experienced by the 441 patients under age 21 (59%) who were programmed into the standard instructional program of the institution.